MODEL APPLICATION TEMPLATE FOR STATE CHILD HEALTH PLAN UNDER TITLE XXI OF THE SOCIAL SECURITY ACT STATE CHILDREN'S HEALTH INSURANCE PROGRAM

Preamble

Section 4901 of the Balanced Budget Act of 1997 (BBA) amended the Social Security Act (the Act) by adding a new title XXI, the State Children's Health Insurance Program (SCHIP). Title XXI provides funds to states to enable them to initiate and expand the provision of child health assistance to uninsured, low-income children in an effective and efficient manner. To be eligible for funds under this program, states must submit a state plan, which must be approved by the Secretary. A state may choose to amend its approved state plan in whole or in part at any time through the submittal of a plan amendment.

This model application template outlines the information that must be included in the state child health plan, and any subsequent amendments. It has been designed to reflect the requirements as they exist in current regulations, found at 42 CFR Part 457. These requirements are necessary for state plans and amendments under Title XXI.

The Department of Health and Human Services will continue to work collaboratively with states and other interested parties to provide specific guidance in key areas like applicant and enrollee protections, collection of baseline data, and methods for preventing substitution of Federal funds for existing state and private funds. As such guidance becomes available; we will work to distribute it in a timely fashion to provide assistance as states submit their state plans and amendments.

MODEL APPLICATION TEMPLATE FOR STATE CHILD HEALTH PLAN UNDER TITLE XXI OF THE SOCIAL SECURITY ACT STATE CHILDREN'S HEALTH INSURANCE PROGRAM

(Required under 4901 of the Balanced Budget Act of 1997 (New section 2101(b)))

State/Territory:_____
(Name of State/Territory)

As a condition for receipt of Federal funds under Title XXI of the Social Security Act, **(42 CFR, 457.40(b))**

_____
(Signature of Governor, or designee, of State/Territory, Date Signed)

submits the following State Child Health Plan for the State Children's Health Insurance Program and hereby agrees to administer the program in accordance with the provisions of the approved State Child Health Plan, the requirements of Title XXI and XIX of the Act (as appropriate) and all applicable Federal regulations and other official issuances of the Department.

The following state officials are responsible for program administration and financial oversight **(42 CFR 457.40(c))**:

Name:	Position/Title:
Name:	Position/Title:
Name:	Position/Title:

Section 1. General Description and Purpose of the State Child Health Plans and State Child Health Plan Requirements (Section 2101)

1.1. The state will use funds provided under Title XXI primarily for (Check appropriate box) (42 CFR 457.70):

1.1.1. ☐ Obtaining coverage that meets the requirements for a separate child health program (Section 2103); OR

1.1.2. ☐ Providing expanded benefits under the State's Medicaid plan (Title XIX); OR

1.1.3. ☑ A combination of both of the above.

Introduction

Shortly after enactment of the federal Children's Health Insurance Program, Governor Wilson developed a program for implementing the Initiative in California. He submitted his legislative package to the legislature in August of 1997 and the legislature worked with the Governor to enact the Healthy Families program in the last weeks of the 1997-98 legislative sessions.

With its Healthy Families Program, California seeks to expand access to health care coverage for uninsured children through:

- Creation of a health insurance program for children whose family incomes are above those which provide eligibility for no cost Medi-Cal up through 200% of poverty;
- Changes to the Medi-Cal system which will improve access by simplifying eligibility; and
- Coverage ~~through the Access for Infants and Mothers (AIM) program~~ of infants up ~~to 12 months~~ through the age of two born to mothers enrolled in the Access for Infants and Mothers (AIM) Program whose family income is between 200-~~250%~~ 300% FPL.

California's program consists of the following pieces of legislation, which are included in the plan as Attachment 2.*

- Chapter 623 (AB 1126 -Villaraigosa) outlines the Healthy Families insurance program which provides affordable private health insurance plans for low-income children either through a health insurance purchasing pool or an insurance purchasing credit. The legislation details program administration, eligibility criteria, monthly premiums, benefits, the program application process, and outreach activities;

*Attachment 1 is a glossary of terms used in the State Plan.

- Chapters 626 and 624 (AB 217 - Figueroa and SB 903 - Lee /Maddy) enact several provisions designed to improve access to Medi-Cal for Medi-Cal eligible children; and
- Chapter 625 (AB 1572 - Villaraigosa/ Gallegos) appropriates start-up funds for the Healthy Families program.

Many children will come to Healthy Families through the Healthy Families "gateway" program, the Child Health and Disability Prevention (CHDP) program. Families of uninsured children receiving health screens from CHDP will be informed about the opportunity for health coverage. Those families wishing to pursue comprehensive coverage will be directed either to Medi-Cal or into the insurance program.

In the insurance program, children will receive health coverage like that provided to California's state employees under California's benchmark plan, the California Public Employees Retirement System (CalPERS). They will also receive comprehensive vision and dental coverage patterned after state employee coverage. Children with certain complicated medical conditions will receive treatment of those conditions through California's highly regarded California Children's Services (CCS) program. Similarly, children with serious emotional disturbances will receive treatment of their condition from county mental health departments. This comprehensive child focused benefits package provides children with preventive, full scope, quality health care which will help promote healthier children and, as a result, healthier families for the state of California.

California will seek to ensure that children's health plans become their medical homes by emphasizing preventive services, coordinating with programs that currently serve the uninsured and weaving quality measurement and monitoring into the fabric of the program. California will require specified performance measures in its contracts with plans and will build on these as additional measures are developed.

The Department of Health Services (DHS) will be responsible for implementing the outreach and Medicaid changes proposed in the Title XXI state plan as well as ongoing administration of the CCS and CHDP programs.

The Managed Risk Medical Insurance Board (MRMIB) will be responsible for administering the purchasing pool, the purchasing credit, and the AIM program. MRMIB has a strong commitment to providing affordable quality health care to Californians. MRMIB currently administers three health insurance programs: the Major Risk Medical Insurance Program (MRMIP), a program for medically uninsurable people, the Health Insurance Plan of California (HIPC), a small employer purchasing pool and the Access for Infants and Mothers (AIM) Program, a program for uninsured pregnant women and their newborns. (The state also seeks FFP for infants through age 2, born to mothers enrolled in ~~a portion of~~ the AIM program.)

ACCESS FOR INFANTS AND MOTHERS (AIM) PROGRAM

The AIM Program provides comprehensive health benefits for pregnant women and their infants through the age of 2 with household incomes between 200% - 300% FPL. In addition, pregnant women are not eligible for AIM if they are on Medi-Cal or have employer-sponsored coverage (unless the coverage has such high deductibles that MRMIB views the coverage as being tantamount to being uninsured). As approved in California's SPA, FFP is claimed for infants through the age of 1, born to AIM mothers with household incomes between 200% - 250% FPL.

In an effort to streamline public programs, California is in the process of modifying its AIM Program statute to change the eligibility process and benefit service delivery for infants and children up to the age of 2 born to mothers enrolled in AIM. AIM will continue to serve pregnant women with incomes up to 300% FPL. Eligibility, enrollment, plan selection and benefit service delivery through the AIM Program remain for the pregnant woman. However, infant's born to mothers enrolled in AIM will be enrolled in the Healthy Families Program from date of birth until age 2. The Healthy Families Program will conduct an annual redetermination prior to the child's first birthday to assure eligibility for the child's second year of coverage, i.e. income equal to or less than 300% FPL.

Providing coverage to infants and children through age 2 born to mothers enrolled in AIM provides a greater selection of health plans, provides access to the CCS provider network for children with an eligible CCS condition, and provides dental and vision coverage. California is in the process of combining the administrative functions of both programs into one administrative vendor. Based on an economy of scale within the Healthy Families Program, pregnant women enrolled in the AIM Program will receive: an increase in the hours of available toll free telephone support; written materials and telephone operators to support more languages; and, most importantly, seamless enrollment for the infants into the Healthy Families Program.

MRMIB has provided to the Administration the necessary modifications to the AIM Program statute and this language is included in the health trailer bill accompanying the Governor's proposed FY 2003-04 Budget. Pending Legislative approval, California submits this SPA to request federal approval for FFP under Title XXI up to 300% FPL for infants and children through age 2, born to mothers enrolled in the AIM Program and enrolled in the Healthy Families Program.

COUNTY CHILDREN'S HEALTH INSURANCE PROGRAMS (C-CHIP)

AB495 (Diaz) (Chapter 648, statutes 2001) authorized the MRMIB to establish a mechanism to permit county agencies, Local Initiatives (LIs), and County Organized Health System (CHOS) to utilize federal Title XXI (S-CHIP) funds not needed by the State for coverage of children or parents in the Healthy Families Program. Funds would be used to expand

coverage for uninsured children with income at or below 300 percent FPL and not eligible for no cost Medi-Cal or the Healthy Families Program. California submits this SPA to establish the mechanism for Santa Clara Health Plan, Alameda Alliance Family Care, and San Francisco County Health Plan, all Local Initiatives, and Health Plan of San Mateo, a County Organized Health System for their respective counties. The California Welfare and Institutions Code section 14087 establishes the governing authority for Local Initiatives and County Organized Health Systems.

C-CHIP enrolled children will receive health coverage from the health plan noted above that also serves as the counties' LI or COHS and also a Healthy Families health plan. Health benefits are the same as in the Healthy Families Program, except for the specialized services carved out for CCS. Under the C-CHIP model, children diagnosed with an eligible CCS condition will be referred to the CCS program for a full eligibility determination, including financial eligibility. In the Healthy Families Program, enrolled children with an eligible CCS condition are "deemed" to meet the financial eligibility requirements. In C-CHIP, children that do not meet all the CCS eligibility criteria will have all their medical needs met by the health plan as happens today under the California State Employees coverage that serves as the benchmark coverage for the Healthy Families Program. Children enrolled in the C-CHIP will also receive comprehensive dental and vision coverage patterned after the Healthy Families Program.

C-CHIP will be administered by the LIs and the COHS. Application screening to assure children are not eligible for no cost Medi-Cal or Healthy Families will be done via application assistants who are already trained in Medi-Cal and Healthy Families Program criteria. Enrollment into the LIs and the COSH will occur by the health plan staff. To assure consistency among all the public programs, eligibility criteria are the same as in the Medi-Cal and Healthy Families Programs except that C-CHIP covers income at or below 300 percent FPL.

MRMIB is responsible for review and ongoing monitoring of each of the C-CHIP expansions to assure compliance with federal Title XXI regulations and California's approved state plan.

1.2. ☑ **Please provide an assurance that expenditures for child health assistance will not be claimed prior to the time that the State has legislative authority to operate the State plan or plan amendment as approved by CMS. (42 CFR 457.40(d))**

1.3. ☑ **Please provide an assurance that the state complies with all applicable civil rights requirements, including title VI of the Civil Rights Act of 1964, title II of the Americans with Disabilities Act of 1990, section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, 45 CFR part 80, part 84, and part 91, and 28 CFR part 35. (42CFR 457.130)**

1.4. ☐ **Please provide the effective (date costs begin to be incurred) and implementation (date services begin to be provided) dates for this plan or plan amendment (42 CFR 457.65):**

Effective date: January 1, 2003

Implementation date: January 1, 2003

Section 2. General Background and Description of State Approach to Child Health Coverage and Coordination (Section 2102 (a)(1)-(3)) and (Section 2105)(c)(7)(A)-(B))

2.1. Describe the extent to which, and manner in which, children in the state including targeted low-income children and other classes of children, by income level and other relevant factors, such as race and ethnicity and geographic location, currently have creditable health coverage (as defined in 42 CFR 457.10). To the extent feasible, make a distinction between creditable coverage under public health insurance programs and public-private partnerships (See Section 10 for annual report requirements). (42 CFR 457.80(a))

According to the Current Population Survey (CPS) data analyzed by the UCLA Center for Health Policy Research, most California children currently have access to creditable health coverage. According to CPS data for 1995, 7,636,000 children had insurance coverage, with most of those (4.9 million or 53 percent of all children) having coverage through job-based insurance. In 1995, 2,345,000 (25 percent of all children) were served by Medi-Cal, the state's Medicaid program.[1] Another 124,000 children (1 percent) were covered through other public insurance such as Medicare or CHAMPUS, while 291,000 children (3 percent) had access to privately purchased insurance coverage in 1995. However, 1.6 million California children were uninsured, an estimated 17 percent of all California children.

Public Health Care Programs for Children. As was noted above, most California children obtain their coverage through private means. However, a significant number are served through public programs. The public programs under which children may get coverage include the following:

Medi-Cal. California's largest public health insurance program serving children is Medicaid (known in California as Medi-Cal).

- Most children are served under the categorically needy categories (SSI/SSP and AFDC/TANF recipients).
- The Medically Needy program under Title XIX, Section 1902(a)(10)(C) provides benefits to children under age 21 who meet resource requirements and who are determined otherwise eligible.
- The Federal Poverty Level programs under Title XIX, Section 1902(l) provides

1 The California Department of Health Services believes that CPS data significantly underestimate the number of beneficiaries served by Medi-Cal.

benefits to children under age 19 who are determined otherwise eligible. The FPL programs are as follows:

- For infants up to age one: family income must be at or below 200 percent of FPL, the income (between 185 percent and 200 percent) and the resources of the parents and child are disregarded.

- For children age one and under age six: family income must be at or below 133 percent of FPL.

- For children who have attained the age of six, who were born after September 30, 1983, but who have not attained the age of 19: family income must not exceed 100 percent of FPL.

- State legislation to provide for Medi-Cal coverage under Title XXI of children under 19 and born before September 30, 1983 has just been enacted.

- Presently, resources are counted for children ages 1 to 19 in the FPL program. However, state legislation has just been enacted to disregard the resources of the parents and child in the FPL program which will expand Medi-Cal coverage under Title XXI.

California Health Care for Indigents Program (CHIP). CHIP provides funding to large counties for uncompensated hospital, physician, and other health service costs.

To be eligible for CHIP funds, counties must meet their Maintenance of Effort (MOE), and provide or arrange for follow-up medical treatment for children with health problems and/or medical disorders detected through the CHDP program.

Rural Health Services (RHS). RHS provides funding to small rural counties for uncompensated hospital, physician, and other health services costs.

To be eligible, counties must participate in the County Medical Services Program, meet their Maintenance of Effort (MOE), and provide or arrange for follow-up medical treatment for children with health problems and/or medical disorders detected through the CHDP program.

The program contracts with the State Office of County Health Services for the rural counties' obligation to provide follow-up treatment for the conditions identified in CHDP screens.

Expanded Access to Primary Care (EAPC) Program. EAPC provides financial assistance to primary care clinics serving medically-underserved areas or populations. EAPC is funded through Proposition 99 tobacco tax monies and serves individuals at or below 200 percent of the poverty level on a sliding scale basis.

Seasonal Agricultural and Migratory Workers Health Program. This program provides financial and technical assistance to primary care clinics serving the needs of seasonal, agricultural, and migratory workers and their families. Individuals pay on a sliding scale.

California Children's Services (CCS). CCS provides funding for medical care for eligible low-income families with children with serious medical problems, such as critical acute illnesses, chronic illnesses, genetic diseases, physical handicaps, major injuries due to violence and accidents, congenital defects, and neonatal and pediatric intensive care unit level conditions. It provides physician, hospital, laboratory, X-ray, rehabilitation services, medications, and medical case management.

To be eligible, individuals must be under twenty-one years of age, have a medical condition covered by CCS, be a resident of the county, have an adjusted gross family income below $40,000 or a projected out-of-pocket medical cost greater than twenty percent of the family income.

Major Risk Medical Insurance Program (MRMIP). MRMIP provides subsidized health coverage to individuals, including children, who are denied coverage by private carriers because of a pre-existing medical condition. People who are eligible for Medicaid or Medicare cannot enroll in this program. Approximately 6% of the program subscribers are children.

Direct health services are frequently provided through community health centers, school based health centers and voluntary practitioner programs.

Access for Infants and Mothers (AIM). The AIM program is a public-private partnership which offers creditable coverage to pregnant women with incomes between 200 percent and 300 percent of FPL and their newborn children through the first two years of life. AIM is administered by MRMIB, which contracts with the private sector to provide subsidized coverage for beneficiaries. To cover the full cost of care, California uses Proposition 99 tobacco tax monies to subsidize subscriber co-payments and contributions, while the subscriber pays two percent of their average annual income. As of September 1997, AIM has provided access to comprehensive health benefits for 28,921 women and 25,735 newborns.

Uninsured Children. The CPS data indicate that the vast majority of uninsured children (1.4 million) live in families with at least one working parent. In fact, 965,000 uninsured children lived in families with at least one parent employed full-time for the entire year. Uninsured rates are highest among children in self-employed families, but lack of insurance is also prevalent among families in which a parent works for an employer.

There are disparities in California's uninsured children's race and ethnicity as well. CPS data show that 29 percent of Latino children are uninsured, in contrast to 12 percent of Asian American children, 10 percent of non-Latino white children, and 10 percent of African American children. Furthermore, uninsured rates for children vary across geographic regions. CPS data show that 25 percent of children in Los Angeles County and 20 percent of children in Orange County are uninsured. In contrast, an average of 16 percent of children in Central Valley counties, 13 percent in San Diego County, an average of 11 percent in Riverside and San Bernardino counties, and 10 percent in the six county San Francisco Bay Area are uninsured.

CPS data estimates reflect that there are 580,000 uninsured California children whose families have incomes between 100 and 200% FPL and this might qualify as targeted low income children under Title XXI, and thus could potentially be served by the Healthy Families program. Given the sample size drawn for CPS, there are no statistically valid demographic data on this population. A copy of UCLA's analysis of the health status of children between 100 percent and 200 percent of poverty is included as Attachment 3.

2.2. Describe the current state efforts to provide or obtain creditable health coverage for uncovered children by addressing: **(Section 2102)(a)(2) (42CFR 457.80(b))**

2.2.1. The steps the state is currently taking to identify and enroll all uncovered children who are eligible to participate in public health insurance programs (i.e. Medicaid and state-only child health insurance):

California currently identifies and enrolls uncovered children who are potentially eligible to participate in public programs in several ways:

- DHS administers its Baby-Cal media campaign, which provides extensive outreach to pregnant women about the importance of obtaining prenatal care, and informs them that, if they have modest incomes, state programs are available to help them. With its annual $6 million budget, Baby-Cal uses a media campaign, operates a toll-free line which, among other things, refers callers to Medi-Cal or the AIM program (as applicable), and conducts outreach through a network of roughly 350 community based organizations (CBOs).

- Child Health and Disability Prevention (CHDP), California Children's Services (CCS), and Women, Infant and Children (WIC) providers identify children who may be potentially eligible for Medi-Cal and refer the family to the appropriate office to apply. State statute requires CCS applicants to fill out a Medi-Cal application.

- To facilitate the application process, Medi-Cal outstations eligibility workers in locations which serve large numbers of potentially eligible children, such as disproportionate share hospitals, prenatal clinics and federally qualified health centers.

2.2.2. The steps the state is currently taking to identify and enroll all uncovered children who are eligible to participate in health insurance programs that involve a public-private partnership:

The Baby-Cal campaign described in Section 2.2.1. targets pregnant women who may be eligible for participation in the AIM program. AIM also works with three community-based outreach contractors in various regions of the state to distribute informational materials via mail and at public events. AIM's contractors conduct other innovative activities such as educating insurance agents about the program, conducting a telemarketing campaign, and producing public service announcements. AIM also conducts outreach through the use of an application assistance fee paid to individuals and entities that assist families in filling out the AIM application.

2.3. Describe the procedures the state uses to accomplish coordination of SCHIP with other public and private health insurance programs, sources of health benefits coverage for children, and relevant child health programs, such as title V, that provide health care services for low-income children to increase the number of children with creditable health coverage. ***(Previously 4.4.5.)*** **(Section 2102)(a)(3) and 2102(c)(2) and 2102(b)(3)(E)) (42CFR 457.80(c))**

The Healthy Families program consists of four components: expansions of coverage under Medi-Cal (as described in Section 2.1); establishment of a purchasing pool for children with family incomes up to 200% FPL (who are ineligible for no-cost Medi-Cal); an aggressive outreach and education campaign to make the public familiar with the availability of health coverage for the uninsured; and provision of coverage under the AIM program for infants and children through age 2, born to mothers enrolled in the AIM Program ~~under the age of 1~~ with family incomes between 200 ~~-250%~~ 300% FPL. This section concentrates on the insurance program and AIM as Medi-Cal's administration is in accordance with California's Title XIX plan.

Insurance Program

The insurance program will serve children whose family income falls below 200 percent FPL but who are not eligible for no-cost Medi-Cal. The program has been designed to have a smooth interface with Medi-Cal and includes a number of provisions to ensure that the insurance program enrolls only targeted low-income children.

Coordination with Medi-Cal:

- Under Title XXI, California will expand Medi-Cal eligibility to implement a resource disregard for children whose countable family income is at or below the appropriate FPL in the Medi-Cal program. Thus, eligibility for both programs will depend only on a family's income. Eligibility workers, CHDP providers, and other organizations assisting families will be able to use an income chart to refer children to the appropriate program.
- Healthy Families will compare its participant list against Medi-Cal's enrollment files to ensure that children do not already have creditable coverage through Medi-Cal.
- To provide families moving from Medi-Cal to Healthy Families with time to enroll in Healthy Families, the Department of Health Services will implement one month of **"**continued eligibility" for Medi-Cal covered children whose family income is at or below the appropriate FPL who lose eligibility for no cost Medi-Cal due to increased family income or increased age of a child.

Coordination with employer-sponsored coverage. The insurance program has been designed to ensure coordination with existing private coverage to reach only targeted low income children:

- The program has a coverage "firewall" -- a prohibition against covering children who have had employer sponsored coverage within 3 months prior to applying for the Program. MRMIB is authorized to increase the length of the period to 6 months if it finds it is covering substantial numbers of children who were previously covered under employer-sponsored plans.
- The program's enabling statute prohibits insurance agents and insurers from referring dependents to the program where dependents are already covered through employer sponsored coverage.
- The program's enabling statute makes it an unfair labor practice for an employer to refer employees to the program for dependent coverage where the employer provides for such coverage or for an employer to change coverage or change the employee share of cost for coverage to get employees to enroll in the Program.

Outreach. A central component to the design of Healthy Families is an extensive outreach campaign. The outreach for the new Healthy Families program is designed to be performed by CHDP providers, community-based organizations, county health agencies, and other entities that are geared to assist targeted low-income families in obtaining needed health and related services. CHDP providers will provide early medical screenings and immunizations (following Early Periodic, Screening, Diagnostic, and Treatment (EPSDT) guidelines) for children under 200% of poverty and will perform a critical eligibility screening and referral function for both Healthy Families and Medi-Cal. Healthy Families outreach will be coordinated with efforts to inform families about the enhancements to children's Medi-Cal coverage that accompany the implementation of the new Healthy Families program. As with the AIM program, entities that are likely to have contact with large numbers of children in the target population, such as school districts and day care centers, and individuals such as insurance agents will be paid a fee for assisting families in filling out the Healthy Families application. The outreach campaign is further outlined in Section 5 of this plan.

Integration of traditional and safety net providers. Counties as well as clinics and certain providers are primary sources of care for Medi-Cal beneficiaries and the uninsured, including children.

Given the critical safety net role these systems play in serving targeted children, the state will facilitate their participation in the purchasing pool. The following features are intended to assist with this process:

- MRMIB will encourage managed care plans to subcontract with safety net providers and require them to report annually on the number of subscribers selecting these providers.
- MRMIB will allow the health plan that has the highest percentage of traditional and safety net providers in its provider network to charge a discounted premium.
- County managed care systems (county organized health systems) are allowed to participate in the pool and given two years to obtain a commercial health plan license.
- MRMIB will give priority in contracting to plans with significant numbers of providers who serve uninsured children.

In summary, the Managed Risk Medical Insurance Board (MRMIB) and the Department of Health Services (DHS) have established a variety of mechanisms by which to coordinate in the administration, monitoring, and evaluation of the programs described in the plan. The mechanisms include:

- Both DHS and MRMIB report to the Secretary of the Health & Welfare

Agency who can ensure that both agencies are operating under consistent policies and procedures;

- Kim Belshé, the Director of DHS, is a MRMIB Board Member. Thus, every issue before the Board is one which Ms. Belshé can comment on to other Board Members and vote on. Furthermore, the Health and Welfare Agency sits on MRMIB as a ex-officio member;
- DHS and MRMIB have created a Healthy Families Core Workgroup consisting of DHS' and MRMIB's senior management. The workgroup meets every other week to ensure coordination of the program. During these meetings, workgroup members provide status reports on the various projects being implemented and discuss implementation issues. This workgroup will continue to meet on a routine basis even after the Healthy Families program has opened;
- DHS staff has provided input to MRMIB staff on every version of the MRMIB Healthy Families regulations, as well as on the model contracts, negotiations and provided input to DHS staff on the application form common to both Healthy Families and Medi-Cal (Medicaid) for children, the outreach contract, and the outreach and media approach. MRMIB has also consulted with DHS staff on a range of issues such as Medi-Cal quality standards, Medi-Cal threshold language requirements, and the definition of traditional and safety net providers;
- DHS has created a new high-level management position (Associate Director) to facilitate coordination of the program within and between agencies. DHS has filled this position with an individual who served as Deputy Director of MRMIB from 1991-1996; and
- DHS staff attends MRMIB's public meetings, including board meetings, and meetings with potential vendors to explain the model contracts.

COUNTY CHILDREN'S HEALTH INITIATIVE PROGRAM (C-CHIP)

The county insurance program, similar to the Healthy Families Program, serves uninsured children whose family income do not exceed 300 percent FPL and who are not eligible for no cost Medi-Cal or the Healthy Families Program and who are otherwise eligible for S-CHIP funding. C-CHIP is a county based program only available in counties that have local funds allocated for its implementation. Eligibility and enrollment in these programs are operated by the local county government, LIs or COHSs.

Coordination with Medi-Cal and the Healthy Families Program. Since the C-CHIP projects are sponsored and funded from local funds, there are built in financial incentives to local counties to assure coordination with Medi-Cal and the Healthy Families Programs. More children can be covered at the county level using local dollars if they are not financially sponsoring children who could otherwise be covered

by state and federal dollars.

- C-CHIP will use the same income standards and deductions as the Medi-Cal and Healthy Families Programs to assure consistency among the programs.
- C-CHIP will use a resource disregard when determining eligibility, again to assure consistency with the Medi-Cal and Healthy Families Programs.
- At the time of initial application, a Medi-Cal and Healthy Families screening will occur. Applications with children screened to Medi-Cal or Healthy Families will be submitted to the State's single point of entry for processing. Most counties have indicated that they will use Health-e-App, the state's internet based electronic application that provides a Medi-Cal and Healthy Families eligibility screening as the mechanism by which to assure children are not enrolled in C-CHIP in error.
- As with the initial eligibility determination, annual reviews will occur to assure continued eligibility for C-CHIP, including the Medi-Cal and Healthy Families screening.
- The State will also modify its annual review process to include forwarding applications to counties known to have a C-CHIP when a child is determined to have income above Healthy Families guidelines.

AIM

The authorizing statute for the AIM program includes the same prohibitions as mentioned above regarding insurance agent referral and unfair labor practices. It also will not provide coverage to a woman on Medi-Cal or who has employer-sponsored coverage (unless the coverage has such high deductibles that MRMIB views the coverage as being tantamount to being uninsured.)

California has historically served mothers and infants through its AIM program even if they have high deductible insurance coverage ($500 or more), because at the income of AIM mothers (200-300 percent FPL), out of pocket expenditures are so unaffordable that most mothers will be unable to use the insurance. The babies of these women may or may not have coverage once born. However, as Title XXI precludes states from serving children who have current insurance coverage, even this high deductible coverage, California will not bill the federal government under the Title XXI program to serve any infant who has access to other coverage. The AIM application asks not only whether a mother has coverage for her pregnancy, but whether that insurance will cover the infant that results from the pregnancy.

The AIM program has received a total of 30,146 successful applications to date, approximately 6 percent of who qualified because of high deductible coverage. A total of 1,228 of these applicants indicated that their infants had access to other insurance coverage, 4 percent of the total application pool. California will track

insured status of infants enrolled in AIM and will not claim federal financial participation for children whose mothers report the availability of health coverage for the infants. ~~For estimation purposes, California has assumed that 4 percent of the children will continue to be ineligible for participation in Healthy Families.~~ Thus, MRMIB will bill for ~~96 percent of the~~ children under age ~~one~~ two whose family income is between 200 percent and ~~250~~ 300 percent of FPL and who are uninsured. Actual claims to the federal government will be based on the data collected on infant's insurance status from the AIM application.

~~Children in the AIM program receive virtually the same set of health services as children in the Healthy Families program. These services are also quite similar to those of the Health Insurance Plan of California (HIPC). All of these services were patterned on the Public Employee Retirement System (PERS) services.~~

Section 3. Methods of Delivery and Utilization Controls (Section 2102)(a)(4))

☐ **Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan, and continue on to Section 4.**

3.1. Describe the methods of delivery of the child health assistance using Title XXI funds to targeted low-income children. Include a description of the choice of financing and the methods for assuring delivery of the insurance products and delivery of health care services covered by such products to the enrollees, including any variations. **(Section 2102)(a)(4) (42CFR 457.490(a))**

Overview of the Comprehensive Healthy Families Delivery System

California's approach is to serve targeted low income children through an integrated system of care. The central component of this system is a new program to provide creditable health insurance coverage through managed care, a program which will be administered by MRMIB. MRMIB will provide managed care to targeted low-income children between ages 1 and 19, and children under age 1 with incomes between 200 and 250 percent FPL through a health insurance purchasing pool. Through the purchasing pool the state will deliver a comprehensive range of health services to targeted low income children. The state will use the power of pooled purchasing not only to obtain affordable coverage for uninsured children but also to demand high quality services for children.

Many children will come to Healthy Families through a "gateway" program, the CHDP program. CHDP offers preventive health services to children under 200 percent of poverty. When children receive services from a CHDP provider, they will either be referred to Medi-Cal or to the Healthy Families insurance program. Should follow up treatment be required for a condition identified in the CHDP screen, Medi-Cal or the insurance program (depending on which program the child qualifies for) will cover the cost of care provided to children for 90 days prior to enrollment. Low income children who are ineligible for Medi-Cal or the insurance program will be referred to counties for treatment.

To meet the special needs of children, the Healthy Families program will also ensure the provision of necessary specialized services beyond those offered through the comprehensive insurance package in a coordinated manner. The CCS program and county mental health departments will address the significant needs of the minority of children whose needs may not be fully met under an insurance benefit package. The CCS program will provide case management and treatment for chronic, serious, and complex physically handicapping conditions, while county mental health departments will provide appropriate services to meet the needs of seriously emotionally disturbed children. Both programs will reimburse providers for these specialized services.

Children receiving such services will continue to have their primary health needs served through the insurance program. Allowing those specialized services to be provided as a complement to, but outside of, the managed care setting is consistent with recent actions in the Federal budget reconciliation act which prohibit mandatory enrollment of children with special medical needs in managed care.

To promote a smooth interface between Healthy Families and Medi-Cal, Medi-Cal will be enhanced through a resource disregard for children in the federal poverty level program, accelerated coverage for all children under 100 percent of the federal poverty level, and an additional one month of continued eligibility to allow children whose families become ineligible for Medi-Cal time to become enrolled in the insurance program. In addition to program integration, these features will promote greater coverage of children who are already eligible for, though not enrolled in, Medi-Cal. Under this Medicaid expansion, children without health insurance will receive their coverage under Title XXI funding. Children with health insurance will receive their coverage under Title XIX funding with the applicant's other health coverage requirements being applied.

Targeted low income children under age ~~1~~ 2 whose mothers are enrolled in AIM and whose families have incomes between 200- ~~250%~~300% of federal poverty level will be served through the ~~AIM Program, under a purchasing pool arrangement similar to the Healthy Families purchasing pool, or through the~~ Healthy Families Program. The Healthy Families Program will redetermine eligibility prior to the child's first birthday. Prior to the child's second birthday, the Healthy Families Program will redetermine eligibility for the S-CHIP Healthy Families Program.

The authorizing statute for Healthy Families also requires the state to assess the need for specialized services in two additional areas: rural health and substance abuse.

Rural health. The Department of Health Services (DHS) is authorized to operate up to five pilot programs in rural areas should the coverage provided through the insurance programs be insufficient in particular rural areas or for particular populations, such as migrant workers or American Indians. DHS will be meeting with stakeholders in rural areas as well as holding a public hearing in the fall of 1997 to begin to assess these issues. A final determination will be made in early 1998, after MRMIB has finished negotiations with plans for the purchasing pool and, thus, are aware of the extent of the coverage in rural areas. Should DHS, relying on the advice of the Rural Health Policy Council and the County Medical Services Program Board in evaluating the need for supplemental services, determine that supplemental services are needed, California will submit an amendment to this plan.

Substance abuse. The authorizing statute directs MRMIB, in consultation with the Department of Alcohol and Drug Programs, to assess the feasibility of providing

supplementary services for substance abusers. The core benefit package includes those services made available to state employees, but some have argued that additional services are necessary for the target population. MRMIB will report to the legislature on the need for additional services by April 15, 1998. The state will submit an amendment to this plan if it wishes to expand substance abuse services.

Healthy Families Purchasing Pool

Delivery System. For the majority of eligible families, MRMIB will offer access to health plans through a subsidized consumer choice purchasing system. The pool will be built around the concepts used successfully by organized purchasers such as the California Public Employees Retirement System (CalPERS) and HIPC -- price competition among managed care health plans, family choice of plans, performance based contracts with plans, and reliance on existing private sector delivery systems. In the purchasing pool, many of the same health plans and networks available in the employer market will be available to beneficiaries, providing broad access to health care providers. Most of the plans participating will be health maintenance organizations (HMOs), but it is possible that one or more preferred provider organizations (PPOs) will also participate. PPO's participate in several of MRMIB's programs and are a particularly effective means of providing coverage in areas with little or no penetration by HMO's.

Plan Contracting. MRMIB is authorized to contract with licensed health plans and health insurers as well as Local Initiatives approved by the Department of Health Services to provide service to Medi-Cal beneficiaries, County Organized Health Systems (COHS), and federal Health Insuring Organization demonstration projects such as Santa Barbara's COHS. Participating plans will be under the regulatory authority of California's Department of Insurance or Department of Corporations, and subscribers will be able to take any benefit grievances to those regulators. Eligibility grievances are appeal able to MRMIB. COHS are presently overseen by the Department of Health Services, but will be required to obtain Knox-Keene licensure within two years to participate in Healthy Families.

To assure that health care providers currently serving low income families are given the opportunity to participate in the program:

- MRMIB will encourage private managed care plans to subcontract with safety net providers and require them to report annually on the number of subscribers selecting these providers.
- MRMIB will allow the health plan in each county that has the highest percentage of traditional and safety net providers in its provider network to charge a discounted premium.
- County managed care systems (county organized health systems and Local

Initiatives) are allowed to participate in the pool and, in the case of COHS's, given two years to obtain licensure as private health plans.
- MRMIB will give priority in contracting to plans with significant numbers of providers who serve uninsured children.

Plan Contracting Process. The process that MRMIB will use to contract with health plans will be the process it uses to contract with health plans under its three existing programs. MRMIB will first adopt (emergency) regulations detailing the eligibility, benefits and appeals process for the program. It will then issue model contracts, one for the administrative function, and one each for health, dental, and vision plans, which specify MRMIB's contracting requirements. The model contracts issued by MRMIB serve as the basis of negotiations with all vendors. These contracts will contain numerous requirements, ranging from quality standards, participation of safety net providers, communication standards, grievance procedures, and manner of payment. Many of the provisions will be aimed at developing a medical home for children. These provisions include:

- Performance standards regarding provision of health promotion service, such as immunizations;
- Requirements that families receive ID cards, evidence of coverage documents, and physician and hospital directories on the effective date of coverage;
- Requirement to report on grievances; and
- Requirements to publish materials in specified languages.

MRMIB traditionally contracts with health plans for two years. It continually refines and improves the requirements of the contract prior to each new contracting period. It will be able to incorporate in subsequent contracts the indicators of a high quality medical home once such measures have been developed.

Both the regulations and the model contracts will be adopted in public session by MRMIB after the public has had the opportunity to testify on them. Once the model contracts are adopted, MRMIB staff will meet with any and all potential contractors. Those interested in participating will be required to submit signed contracts, together with their price for services, at a certain time. MRMIB staff will review contracts for compliance with requirements and MRMIB will select contractors offering the state the best value. MRMIB can select as few or as many health, dental, and vision plans as it deems appropriate and is not constrained to select the lowest bidder(s).

MRMIB has a reputation for expeditious implementation of the programs it administers. Each of the three existing MRMIB programs opened for enrollment within nine months of enactment of authorizing legislation. Mindful of the urgent needs of California's uninsured children, MRMIB has adopted a similarly aggressive schedule for enrollment to the pool.

Administration. The purchasing pool and purchasing credit components of the program will be privately administered under the oversight of MRMIB. A mail-in application process will be used, and eligibility determination will be completed within an estimated ten days. The application (intended to be as similar as possible to a planned redesigned Medi-Cal application for children) will be designed to verify the income eligibility of families and to screen them for access to employer sponsored coverage as well as coverage under no cost Medi-Cal. As is done in the AIM program, income eligibility will be verified using copies of last year's federal income tax forms or current year wage stubs. A random sample of applications will be audited using the Income Eligibility Verification System (IEVS) on an on-going basis to ensure the fiscal integrity of the program.

The administrative contractor will be responsible for eligibility determination, premium collection, transmission of enrollment information to health plans, and printing and mailing of application materials.

In addition, an application assistance payment will be made to entities able to refer large numbers of children to the program. The types of entities anticipated to be authorized by MRMIB for receipt of the fee include state maternal and child health contractors, school districts, parent-teacher associations, Healthy Start sites, county health departments, county welfare offices, licensed day care operators, and insurance agents or brokers. A flat fee of $50 will be paid to the referring entity for every family that is determined to be eligible for and enrolled in the program.

Quality Oversight. Consistent with its administration of its three existing programs, the MRMIB will look to the state regulatory entities to assure the basic quality of health plans with regard to financial stability, adequacy of network, and appropriateness of medical policy. In addition, to ensure that a health plan becomes a child's medical home, the best practices available for quality improvement and monitoring will be adopted. Such performance standards could include assuring the accessibility of services (such as wait time for appointments) and the delivery of preventive treatments (such as improvements in the percentage of children that are fully immunized by age two).

Coordination with Other Programs. MRMIB will encourage all plans to develop protocols to screen and refer children needing services beyond the scope of the program's benefit package to public programs providing such services and to coordinate care between the plan and the public programs. This could include the regional centers for the developmentally disabled, county substance abuse programs and local education agencies.

MRMIB will also be coordinating eligibility with the state Medi-Cal program by

referring children who appear to be eligible for Medi-Cal to the county for follow-up. MRMIB and Medi-Cal are also assessing the feasibility of using the same application form for both programs so that applications could simply be mailed for processing.

The application assistance fee, which MRMIB will pay for referrals of eligible children, is another feature which will facilitate coordination with public and private entities. MRMIB will specify those agencies and persons in regulation after public hearing, but anticipates authorizing a wide range of entities including insurance agents, PTA's and county maternal and child health contractors.

Outreach Efforts. A statewide outreach effort will be launched to inform parents about the child health services offered through programs such as Healthy Families and Medi-Cal. The outreach program will use mass media, toll free phone lines, community based organizations, and coordination with other state and local programs to deliver messages that are culturally and linguistically appropriate. (See Section 5 for a more detailed description of the outreach activities.)

Child Health and Disability Prevention Program

To maximize access, continuity of care, and ease of administration, the existing CHDP program which provides preventive health screening examinations for children with family incomes of less than 200 percent of the federal poverty level will be integrated into the design of the Healthy Families program. CHDP is a logical point of entry for the target population to be served for many reasons:

- Targeted low income children eligible under Title XXI currently access preventive health services offered through CHDP;
- CHDP providers are likely to be the providers in the child health insurance plans and serve as the "medical home" for children enrolled in plans; and
- Integrating CHDP as a component of Healthy Families provides the new program with acceptability and credibility for providers and families.

To assure that uninsured children in the target population move smoothly into enrollment in either the Healthy Families or Medi-Cal programs, California will adopt a form of limited retroactive eligibility. Once enrolled in one of the programs, a child will be provided 90 day retroactive eligibility to the date of the screening visit for payment for services related to health, dental or vision care needs identified at the initial visit. The cost of these services will be reimbursed on a fee for service basis (at Medi-Cal rates) during the period from application to enrollment and will be paid by Medi-Cal for children enrolled in Medi-Cal and by MRMIB for children enrolled in the insurance program.

A streamlined system will be developed which will provide for identification of

eligibility for Healthy Families or Medi-Cal at the time of a health screening so that providers have a mechanism for delivering care and receiving payment. The services available during this period of retroactive eligibility will be specified in regulation. Appropriate referral will also be made to the CCS program if the problem identified through the screening examination appears to be a CCS eligible condition. To ensure continuity of care whenever possible, referrals for treatment services will be made to providers in the Healthy Families insurance plan which the family has chosen. During the period between application and enrollment, the county CHDP program can assist with identification of providers, scheduling appointments for identified health care needs, coordination of services, and completion of the application form.

Specialized Services

Mental Health. A basic benefit package of mental health services will be provided by the health care plans. This basic package for mental health treatment includes 20 outpatient visits, and 30 inpatient mental health days per year. While it is anticipated that the great majority of the mental health needs of children will be met under the insurance benefit package, it is recognized that some seriously emotionally disturbed children will require more specialized mental health services. Consistent with the treatment of similarly situated privately insured populations, these children are eligible for specialized mental health services through the county mental health system of care. Children with serious emotional disturbances (estimated at between 3-5% of the general population) will be referred by the health care plan to the county mental health program for treatments, pursuant to a Memorandum of Understanding (MOU) between the two organizations for any needed additional mental health services.[2] The required MOU will formalize this important arrangement. (The description of services available is in Attachment 6.) The county mental health program will coordinate the

2 *Definition of Serious Emotional Disturbance from Welfare and Institutions Code:* "For the purposes of this part, 'seriously emotionally disturbed children or adolescents' means minors under the age of 18 years who have a mental disorder as identified in the most recent edition of he Diagnostic and Statistical Manual of Mental Disorders, other than a primary substance use disorder or developmental disorder, which results in behavior inappropriate to the child's age according to expected developmental norms. Members of this target population shall meet one or more of he following criteria:

(A) As a result of the mental disorder the child has substantial impairment in at least two of the following areas: self-care, school functioning, family relationships, or ability to function in the community; and either of he following occur:
  (I) The child is at risk of removal from home or has already been removed from the home.
  (II) The mental disorder and impairments have been present for more than six months or are likely to continue for more than one year without treatment.

(B) The child displays one of the following: psychotic features, risk of suicide or risk of violence due to a mental disorder.

(C) The child meets special education eligibility requirements under Chapter 26.5 (commencing with Section 7570) of Division 7 of Title 1 of the Government Code." [For the purposes of the Child Health Initiative, the age range will be expanded to age 19 years].

delivery of mental health and other health services with the health care plan for those children who meet the criteria of serious emotional disturbance.
County mental health programs will provide mental health treatment services directly or through contracts with private organizations and individual providers. The requirements for provider selection and quality improvement for these mental health services will be consistent with those used for the Medi-Cal program for a similar population.

California Children's Services Program. Integrating the CCS program into Healthy Families is a logical way to ensure that uninsured low income children with serious health conditions will continue to have access to a program highly respected by the medical community because of its focus on high quality care. Children with chronic, serious, and complex physically handicapping conditions are best served by systems and programs which have been organized specifically to serve them. It is important that care not be disrupted and that continuity and quality of services be maintained. With these goals in mind, plans will be required to refer CCS-eligible children to the CCS program for the treatment of CCS-eligible conditions.

CCS, the Title V designated program for children with special health care needs, provides medical case management and payment for health care services for those children with eligible medical conditions who live in families with annual incomes below $40,000. Coverage is, and will be, limited to coverage of the specific condition. The program establishes standards for approval of inpatient hospital facilities and pediatric specialty and subspecialty providers delivering care to eligible children. The program also has an extensive system of special care centers located at tertiary medical centers at which multispecialty, multidisciplinary teams deliver coordinated inpatient and outpatient care to children with chronic medical conditions. The centers include cardiac, chronic pulmonary disease, hematology and oncology, myelomeningocele, hemophisia, sickle cell, renal, infectious disease/immunology, hearing and speech, metabolic disorders, inherited neurologic disease, limb defect, gastroenterology, craniofacial anomalies and endocrinology. The program also approves neonatal intensive care, pediatric intensive care, and pediatric rehabilitation units.

CCS program staff determines the appropriate source of health care for eligible children, assist families in accessing care, and identify other needs of the child and family that could impact the care of the eligible condition.

The services to treat the CCS eligible medical condition of a child enrolled in Healthy Families will not be the responsibility of the contracting health plan in which the child is enrolled. The CCS program will continue to authorize the medically necessary services to treat the condition using the program's regulations, policies, procedures and guidelines in determining the appropriateness of providers, and the necessity for

services. CCS will expand the systems of communication that have been instituted to work with Medi-Cal managed care plans that have CCS services "carved out" from their capitation rate. Local CCS programs carefully coordinate the authorization and delivery of specialty and subspecialty services with the primary care provider to which the child is assigned.

COUNTY CHILDREN'S HEALTH INSURANCE PROGRAM

Delivery System. Service delivery in the C-CHIP will be provided by the counties' LI or COHS. These health plans are health maintenance organizations and also contract with MRMIB to participate in the Healthy Families Program. Having these same plans available is an asset to families in that they may assume continuity of care should they go from enrollment in the C-CHIP to Healthy Families and visa versa.

Administration. The C-CHIP will be administered by the county LI or COHS. The LI or COHS will be directly responsible for final C-CHIP eligibility determinations, enrollment in the LI or COHS, distribution of written materials including correspondence, billing statements, Evidence of Coverage booklet, and premium collection, etc. MRMIB will oversee program activities to assure compliance with federal Title XXI regulations. MRMIB has reviewed the following materials to provide this assurance:

- The C-CHIP application, to assure that all necessary data is collected.
- Policies and procedures for determining eligibility (including citizenship/immigration status) and enrollment, documentation requirements, appeals processes, and enrollee protections such as continued enrollment during an appeal.
- All C-CHIP template correspondence to be used in communicating with the applicants.

Medi-Cal

As part of the Healthy Families program, the state enacted a number of changes to Medi-Cal designed to ease the entry of Medi-Cal eligible children into the Medi-Cal system and establish a more consistent eligibility standard for children. Specifically the state enacted legislation to:

- Disregard resources of the parent and child, for children between ages 1-19 in the Federal Poverty Programs, thereby expanding coverage under Title XXI for children whose families meet Medi-Cal's income standards but who have not met its resource standards;
- Provide one month of continuous eligibility to be used by families who no longer qualify for no share of cost Medi-Cal to transition to Healthy Families private insurance;

- Require development of a simplified Medi-Cal form which can be mailed in; and
- Make eligible for Medi-Cal at 100% or less of FPL, children under age 19 who were born before September 30, 1983 (children age 14-19). This means that children aged 6-19 will be eligible at 100% or less of FPL.

Funding for children who meet the criteria above who are uninsured will be funded by Title XXI while funding for children with private coverage will be by Title XIX.

The delivery system for targeted low income children served by Medi-Cal will be consistent with the existing Title XIX state plan. The appropriate Title XIX state plan amendments are included with this proposal. See Attachment 4.

AIM

The AIM program provides creditable coverage to pregnant women with incomes between 200 percent and 300 percent of FPL and their newborn children through the first two years of life. AIM is administered by MRMIB, which contracts with the private sector to provide subsidized coverage for beneficiaries. Because Medi-Cal currently serves infants under 1 year of age through 200 percent of FPL, infants through age 1 up to 250 percent of poverty served by AIM fall within the income range of targeted low income children. Consistent with the C-CHIP projects, the same income disregards will be applied to children born to mothers enrolled in AIM through age 2. AIM's delivery system and contracting standards are virtually identical to that of Healthy Families' purchasing pool described above. Nine health care service plans participate in AIM, which offers statewide coverage, and the vast majority of all beneficiaries are offered a choice of two plans in each region (three in Los Angeles County).

3.2. Describe the utilization controls under the child health assistance provided under the plan for targeted low-income children. Describe the systems designed to ensure that enrollees receiving health care services under the state plan receive only appropriate and medically necessary health care consistent with the benefit package described in the approved state plan. **(Section 2102)(a)(4) (42CFR 457.490(b))**

Health Insurance Programs

MRMIB will contract with managed care plans which will receive a specified amount per enrollee per month.

Virtually all of the plans will be regulated by California's Department of Corporations (DOC) under a body of law - the Knox-Keene Act - established specifically for

managed care plans.[3] The Knox-Keene Act prescribes rules for the organization of health maintenance organizations and other managed care entities. It specifies plan standards, marketing rules, and consumer disclosure requirements. It also establishes fiscal solvency requirements and quality assurance standards. Specific Knox-Keene requirements include:

- *Medical decision making*. The Knox-Keene Act requires medical services to be sufficiently separate from administrative and fiscal management so that medical decisions are not unduly influenced by fiscal concerns. DOC conducts an onsite medical survey at least every three years. Plans have physician medical directors responsible for medical decision making and directing quality assurance programs.

- *Basic health care services*. Knox-Keene plans must provide the following basic services: physician services, inpatient and outpatient services, diagnostic and therapeutic lab and radiologic services, home health care, preventive health care, and emergency health care, including ambulance and out-of-area coverage. In addition, there are a number of statutory mandates to provide or offer specific benefits.

- *Accessibility of services*. DOC must review and approve provider networks and contracts. Primary care services must be within 30 minutes or 15 miles of the enrollees' residence or workplace. Regulations require at least one primary care provider (FTE) for every 2,000 enrollees as guideline. DOC may require more providers depending on the area, population density, and other factors. Different requirements may apply in rural or medically underserved areas. DOC assures reasonable access to ancillary services and tertiary care.

- *Quality assurance*. Plans must have quality assurance programs to review quality of care, which includes as one component a utilization review system. Regulations require a program directed by health providers to review the quality of care being provided, and to identify, evaluate and remedy problems related to access, continuity and quality of care, utilization and monitoring of plan providers.

- *Financial viability*. Plans must file quarterly and annual financial statements and other financial reports. Plans must meet "tangible net equity" requirements and a financial and administrative audit is conducted at least every three years to monitor plan financial viability.

3 Plans regulated by the Department of Insurance are also eligible to participate in the health insurance program as are county organized health systems which are overseen by the Department of Health Services under rules set forh in the Title XIX plan.

- *Consumer protection*. Plans must maintain internal grievance procedures for plan enrollees and appeals may be made to DOC if grievances are not resolved to the enrollees' satisfaction. DOC reviews and approves plan contracts, disclosure forms, marketing materials and advertising to be sure that consumers receive fair and accurate information.

In addition to the Knox-Keene statutory and regulatory requirements for all health plans, MRMIB has developed a number of features for its programs to assure that enrollees are receiving needed health care. A number of these are discussed in Section 7. However, two features associated with the purchasing pool should be pointed out here:

- *Purchasing Pool Structure*. MRMIB will use a purchasing pool structure under which families can choose from among a number of health plans available in their area. Once a year, the program will have an open enrollment period in which families can change health plans for any reason, if they so choose.

  This "vote with your feet" feature means that enrollees dissatisfied with their health plan can easily change to another -- and likely will even be able to switch to one that also includes their own provider. Thus, health plans must work to satisfy their enrollees if they hope to attract and keep large numbers of enrollees.

- *Risk Assessment/Risk Adjustment*. MRMIB is one of the country's leaders in developing and operating a risk assessment/risk adjustment (RARA) mechanism. One of the purposes of RARA is to provide fiscal relief to plans that have attracted a disproportionate share of higher risk enrollees. This mitigates the incentives that a health plan may have to avoid (or provide inadequate treatment to) a higher risk person or population because they will be high cost. Stated alternatively, it seeks to assure that plans with a higher than average risk mix of enrollees have the resources needed to serve their population. MRMIB has successfully operated a RARA mechanism in the HIPC since 1995 and intends to implement such a mechanism in the Healthy Families pool.

Child Health and Disability Prevention Program

The CHDP program, which will serve as an initial screening and treatment entity as well as a referral source for Healthy Families and Medi-Cal eligible children, develops and distributes medical guidelines for health assessments which CHDP providers use as guidance for the CHDP examinations. Duplicate copies of the health assessment reports are submitted by the providers to the appropriate county CHDP program. The

program uses the copies to assist with referrals as needed to assure treatment was provided and to assess the quality of the exams done by individual providers. The state CHDP program analyzes statewide data on the health assessments to determine if children are receiving appropriate preventive health services. Treatment services will be limited to services for which a need was identified in the health assessment. CHDP will develop prior authorization procedures for high cost services. CHDP will respond to requests for prior authorization within 72 hours so that treatment is not delayed.

Specialized Services

California Children's Services Program. CCS is a medical case management program. Program staff determine the appropriate source of health care for eligible children, assist families in accessing care and identify other needs of the child and family that could impact the care of the eligible condition. The program prior authorizes payment of funds for medically necessary services to treat the child's eligible condition and for hospitalized children, does concurrent reviews. This authorization is based on the program's regulations, policies, procedures and guidelines. The program also approves pediatric intensive care units and refers only to specialists meeting standards established by the program.

Mental Health. The county mental health program has responsibility for case coordination and authorization of services to treat serious emotional disturbances. Utilization management requirements for this program will be consistent with those used for the Medicaid program for a similar population and described in the Title XIX plan.

COUNTY CHILDREN'S HEALTH INSURANCE PROGRAM

Health Plan Regulatory Oversight. These plans are regulated by the Department of Managed Health Care, previously the Department of Corporations, under the Knox-Keene Act. The Knox-Keene Act, as previously stated, prescribes rules for the organization of health maintenance organizations and other managed care entities. It specifies plan standards, marketing rules, and consumer disclosure requirements. It also establishes fiscal solvency requirements and quality assurance standards.

Specialized Services.

California Children's Services Program. Children who are enrolled in the C-CHIP and diagnosed with an eligible CCS condition will be referred to the CCS Program for an eligibility determination based on CCS eligibility criteria: CCS eligible condition, residence within the county, and income within CCS financial guidelines. Children not eligible for CCS services shall receive their medically necessary services via the health plan delivery system like the California State Employees system that serves as

the benchmark. C-CHIP eligible children do not have deemed financial eligibility for CCS services; AB495 requires that expansion services be provided without state expense.

Medi-Cal

The expanded Medi-Cal services provided under Title XXI will be provided in accordance with the routine utilization review procedure used in the Medi-Cal program consistent with the Title XIX state plan. The amendments to the Title XIX state plan that allow for these services can be found in Attachment 4.

Access for Infants and Mothers (AIM)

AIM, like the Healthy Families purchasing pool, operates in a managed care environment. The utilization controls used in the program are like those discussed in the above section on the purchasing pool.

Section 4. Eligibility Standards and Methodology. **(Section 2102(b))**

☐ **Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan, and continue on to Section 5.**

4.1. The following standards may be used to determine eligibility of targeted low-income children for child health assistance under the plan. Please note whether any of the following standards are used and check all that apply. If applicable, describe the criteria that will be used to apply the standard. (Section 2102)(b)(1)(A)) (42CFR 457.305(a) and 457.320(a))

4.1.1. ☑ **Geographic area served by the Plan:** The S-CHIP plan is available statewide. The C-CHIP is available in Santa Clara, Alameda, San Francisco and San Mateo counties.

4.1.2. ☑ **Age:** Children from ages 0 to 19 will be served within the insurance program ~~and infants ages 0-1 within the AIM program if they are born to mothers enrolled in AIM~~. Children ages 14-19 with family incomes 85% to 100% FPL will be eligible for Medi-Cal through a Title XXI expansion.

4.1.3. ☑ **Income:** Between 100-200% FPL for the insurance program and 200-~~250%~~ 300% for infants and children through age 2, born to mothers enrolled in ~~for~~ AIM. Medi-Cal uses specific exemptions from income, as is detailed in California's Title XIX State plan. In determining eligibility for Healthy Families, Medi-Cal income exemptions will be applied and all income over 200% FPL but less than or equal to 250% FPL will be disregarded in calculating household income. If the income exemptions and income disregard reduce income to 200% or less FPL, the child will meet the Healthy Families Program income criteria. In determining eligibility for C-CHIP, Medi-Cal income exemptions will be applied and all income over 200% FPL but less than or equal to 300% FPL will be disregarded in calculating household income. If the income exemptions and income disregard reduce income to eligibility to 200% FPL or less and the child is not eligible for the Healthy Families Program, the child will meet the C-CHIP income criteria.

4.1.4. ☐ **Resources (including any standards relating to spend downs and disposition of resources):** The insurance program has no resource requirements. Consistent with this approach, California will waive the resource Medicaid requirements for all children in the Federal Poverty Level program under Medi-Cal. The C-CHIP will also waive resource

requirements consistent with other public programs.

4.1.5. ☑ **Residency (so long as residency requirement is not based on length of time in state):** Children must be residents of California. They must also meet the citizenship and immigration status requirements applicable to Title XXI. Eligibility for C-CHIP will require residency within the county that sponsors an expansion program and meet the citizenship and immigration status requirements applicable to Title XXI.

4.1.6. ☐ **Disability Status (so long as any standard relating to disability status does not restrict eligibility):**

4.1.7. ☑ **Access to or coverage under other health coverage:** Children are ineligible for the insurance program if they have been covered under employer sponsored coverage within the prior 3 months (with certain exceptions described in Section 4.4.4) or if they are eligible for (no cost) Medi-Cal or Medicare coverage. To participate in AIM, pregnant women must not have employer sponsored coverage or no cost Medi-Cal at the time of application.

4.1.8. ☑ **Duration of eligibility:** Annual eligibility determination for Healthy Families. Medi-Cal will establish one month bridging eligibility for children whose family income increases beyond Medi-Cal's eligibility threshold for no-cost Medi-Cal coverage, but does not exceed Healthy Families limits. Infants aged 0-1 in the AIM Program are determined eligible at the time their pregnant mother enrolls and will be redetermined prior to the child's first birthday for continued eligibility. C-CHIP eligibility is for twelve months, at which time an annual eligibility determination will occur.

4.1.9. ☑ **Other standards (identify and describe):**

- Enrollment in the insurance program and AIM will be limited to the number of children that can be served within appropriated funds.

- To be eligible for the insurance program, families must enroll all of their children, pay the first month's family contribution, and (if selecting coverage through the purchasing pool) agree to remain in the pool for at least six months, unless other coverage is obtained and demonstrated. To remain enrolled in the insurance program, families must make their premium

payments. Those who fail to do so will be disenrolled and not allowed to apply again for six months. However, state law stipulates that MRMIB may waive the six month exclusionary period of disenrollment for good cause.

- Children are ineligible for the insurance program if they are eligible for any California Public Employees' Retirement System Health Benefits Program(s), if they are an inmate in a public correctional institution or if they are a patient in an institution for mental illness.

- At the time of application, children enrolled in C-CHIP cannot be eligible for no cost Medi-Cal or the Healthy Families Program.

- To be eligible for AIM, families must agree to pay 2% of the family's gross income ~~plus $100 at the child's first birthday ($50 discount if the child's immunizations are up-to-date on their first birthday)~~. The child's mother must have lived in California for at least six months prior to applying for coverage under the program.

4.2. The state assures that it has made the following findings with respect to the eligibility standards in its plan: (Section 2102)(b)(1)(B)) (42CFR 457.320(b))

4.2.1. ☑ These standards do not discriminate on the basis of diagnosis.

4.2.2. ☑ Within a defined group of covered targeted low-income children, these standards do not cover children of higher income families without covering children with a lower family income.

4.2.3. ☑ These standards do not deny eligibility based on a child having a pre-existing medical condition.

4.3. Describe the methods of establishing eligibility and continuing enrollment. (Section 2102)(b)(2)) (42CFR 457.350)

Insurance Program

MRMIB will contract with a private company to conduct eligibility determinations, premium collection, payment of the application assistance fee and other enrollment functions. This is the same process that it uses for MRMIB's three existing programs.

The State has researched federal law to determine if a proposed administrative vendor who is also a health care plan would violate any federal provisions applicable to title XXI of the Social Security Act. The State has determined that only one federal law, 42 USC 1396a (4)(C), as amended by the Balanced Budget Act of 1997, applies to the Healthy Families Program pursuant to Section 2107(e) of Title XXI. Section 1396a (4)(C) requires that certain officers, employees, and independent contractors be prohibited from engaging in any activity prohibited under Section 207 and 208 of Title 18 of the United States Code. The State intends to comply with these sections and does not think that having a health care plan act as the administrative vendor would violate 42 USC 1396a (4)(C).

Although Title XXI is subject to 42 USC 1320a-7b(b), the State has determined that the section does not apply to the Healthy Families Program because the duties of the administrative vendor would not be activities covered under the section. The vendor will not arrange for health care services or auto assign applicants to any given plan. The applicant makes the choice of health plans and the vendor is prohibited from recommending or steering an applicant to any plan.

In addition, 42 USC 1396v, as amended by the Balanced Budget Act of 1997, which prohibits a health plan from being an enrollment broker for a Medicaid managed care organization, is not applicable to Title XXI.

The firewall requirements established for the administrative vendor (found on pgs. 14, 15, 24, and 25 of the Administrative Model Contract) include:

- Conducting administrative functions of the program in a separate physical area from other business activities;
- Creating an administratively separate organizational structure for staff responsible for the program;
- Blocking access to program databases and files by other parts of the Contractor's organization unless expressly authorized by the State;
- Not using prospecting lists or any other information obtained for the program for use in the Contractor's other business activities;
- Maintaining an open door policy with participating plans, allowing those participating plans to observe its administrative processes, and granting those plans the ability to influence how they are represented by the program's representatives;
- Establishing and maintaining stringent security measures on all hardware, software and program files to ensure the confidentiality and integrity of applicant and subscriber files, and to restrict access to confidential materials;
- Requiring the vendor to develop a process to assure that participating plans' concerns regarding eligibility and enrollment issues are resolved in a timely manner;

- Requiring the administrative vendor to develop and implement a process whereby benefit or participating plan customer service related concerns are traced and transmitted to the appropriate plan for resolution. A summary of these data must be provided monthly to the State;
- Not allowing the administrative vendor selected (health plan or not) to use its company name on program materials. Rather, all materials will refer to the Healthy Families Program;
- Requiring state approval of all published materials, including materials which describe health plans in the application brochure;
- Using scripts prepared by each plan to answer phone inquires about coverage provided by the plan; and
- Requiring any health, dental or vision plan seeking to become the administrative vendor to include in their proposal a statement of how it will assure the separation of plan operations from administrative vendor operations.

Additionally, health plans seeking to become the administrative vendor have suggested additional firewalls in their proposals. MRMIB intends to incorporate these additional firewalls in their contract with the administrative vendor, if it selects a health plan. These include:

- Involving MRMIB in the development of performance based incentive programs for the managerial staff to ensure that the incentives are disassociated from any potential conflicts of interest;
- Providing on-site work space for a MRMIB employee located within the physical unit where HFP administrative activities will take place. The employee will have unrestricted access to HFP administrative facilities and operations, be invited to all internal meetings regarding HFP administration, be able to monitor telephone calls between administrative staff and applicants, and be able to monitor all data systems functions;
- Recording all telephone calls. Tapes of the telephone calls will be made available to MRMIB, health plans, and external auditors, as required;
- Creating links to participating plan websites on the HFP website; and
- Conducting regularly scheduled meetings with participating plans to discuss issues regarding the administrative function. Participating plans will help create the agenda for these meetings. MRMIB will approve any actions proposed at the meetings.

If MRMIB selects a health plan as its administrative vendor, it will use the following strategies to monitor for violations of conflict of interest, in addition to the strategies noted above:

- MRMIB staff periodically will make calls to the vendor posing as potential applicants to see if vendor personnel make any effort to induce them to choose

their company's health plan;

- MRMIB will investigate any complaints by competing health plans or applicants regarding steerage of applicants to one plan over another; and
- MRMIB will track enrollments by health plan and conduct eligibility audits on a periodic basis.

The Healthy Families' administrative vendor will not have the ability to or the responsibility for determining Medicaid eligibility. Medi-Cal application processing and determination will be made by the county welfare office. The application contained in the joint application package contains a worksheet designed to assist families who appear to be eligible for Medi-Cal in mailing their application directly to the county welfare offices. Families who appear to be Healthy Families eligible will mail their applications to the MRMIB administrative vendor who will determine Healthy Families eligibility or ineligibility. If the vendor determines that the child meets Medi-Cal eligibility criteria, the vendor will deny the Healthy Families application, notify the family, return the premiums to the family and, with the family's consent, forward the application to the county welfare office for processing.

Alternatively, in the event that the family incorrectly applies to Medi-Cal, the county welfare offices will, with the family's consent, mail their application to the MRMIB administrative vendor. Once a family has mailed in an application, the "system" will take on the responsibility to see that the application is processed by the appropriate program, but neither will make the other's determination of eligibility.

Families will fill out a simple application and mail it with accompanying supporting documents to MRMIB's enroller. The application/enrollment brochure will be published in English, Spanish, and any other languages designated by the Department of Health Services as a "threshold" language for the Medi-Cal program. Families with questions about the form will be able to call the administrative vendor through a toll free number. Families will be able to speak to the administrative vendor's staff in English or Spanish, and may communicate via other languages through a telephone translation service. MRMIB is authorized to pay certain agencies and individuals such as insurance agents and parent-teacher organizations an application assistance fee for assisting a family with a successful application. The supporting documents that families send to the enroller will include documentation of income eligibility which the administrative vendor will verify using copies of the past year's federal income tax forms, or current year wage stubs. The administrative vendor will audit a random sample of applications on an ongoing basis using the IEVS system to confirm income information. The Systematic Alien Verification System (SAVE) or an appropriate alternative will be used to verify immigration status.

The administrative vendor will review the application within a 10 day time frame and either return it to the applicant for additional information, enroll the child(ren) in a

purchasing pool health plan or enroll the child(ren) in coverage available through the employer. Coverage under the purchasing pool plan will begin 10 days after the application has been determined complete.

On behalf of a child not yet born, families may apply for Healthy Families Program coverage up to three months prior to the expected date of delivery. The infant's 12-month period of eligibility will begin within 13 days after MRMIB receives a notice of the birth. Families that apply for coverage of an infant up to three months prior to birth and experience a change in income prior or after the infant's birth may apply for no-cost Medi-Cal. California will not begin covering children under age 1 in Healthy Families until October 1, 1999, or 90 days after the enactment of the 1999-2000 state budget.

Eligibility will be continuous for 12 months and reestablished annually, unless a child is otherwise made ineligible.

Enrollment in a Health Plan. Families will select their children's health plans when applying for the program. When families are seeking coverage through the purchasing pool, they will choose from among the plans participating in their geographic area. The number of plans from which families can choose will vary depending on the geographic area, as there are fewer managed care plans available in rural areas. In the state's population centers, MRMIB expects families to be able to choose from between 10-15 health plans, dropping down to one or two plans in the most rural parts of the state.

Descriptions of each health plan will be included in the program's application brochure. In the description each plan will list its toll free numbers and describe how families can get copies of its provider directories and evidence of coverage documents. The application and enrollment materials will be available in English, Spanish, and any other threshold language designated by the Department of Health Services.

MRMIB will provide participating families with an annual open enrollment period during which time they may choose to switch plans.

COUNTY CHILDREN'S HEALTH INSURANCE PROGRAM

Health plans (the counties' LI or COHS) will administer the local insurance expansion programs. Since the LI or COHS health plan is the only health plan available in each C-CHIP project, there are no issues related to steerage. The LI and COHS staff will be responsible for eligibility determinations even though state trained application assistants will be used to identify eligible children, assist in completing applications and screening children for the appropriate program: no cost Medi-Cal, Healthy

Families or the C-CHIP. The LI and COHS will also be responsible for premium collection, program enrollment and distribution of health plan materials.

Applications received by C-CHIP that include children potentially eligible for no cost Medi-Cal or the Healthy Families Programs will be forwarded to California's Single Point of Entry for processing. Because of obvious incentives, we believe a quality screening will occur since the Medi-Cal and Healthy Families Programs are state and federally funded while the C-CHIP is county and federally funded. Counties will want to stretch local dollars and still meet objective of reducing the number of uninsured children within the county.

In establishing local expansion programs, the C-CHIPs have adopted most of the Healthy Families rules, including eligibility, documentation, and benefits. The C-CHIPs have established their own applications, although most resemble the one used by the Healthy Families Program.

Medi-Cal

Eligibility will be established and enrollment continued in a manner that is consistent with the state's Title XIX plan.

AIM

MRMIB presently contracts with a private company, ~~Maxicare - Health Care Alternatives~~ Care 1st, which serves as the administrative vendor for the program. Effective January 1, 2004, MRMIB will have a new administrative vendor contract to handle daily operations of both the Healthy Families and AIM Programs.

Families fill out a four-page application and mail it, with accompanying supporting documents, to MRMIB's administrative vendor. Applications are available in English and Spanish. Certain agencies (such as county health departments or maternal and child health contractors) and providers (such as physicians and registered nurses) specified by MRMIB can obtain a $50 application assistance fee for assisting a family with their (successful) application. The supporting documents families send include documentation of income eligibility which the administrative vendor verifies using copies of the past year's federal income tax forms, or current year wage stubs.

~~Maxicare~~ Care 1st reviews the application within a 10 day time frame and either requests ~~returns it to the applicant for~~ additional information from the applicant or enrolls the pregnant woman in the purchasing pool health plan selected by the woman. Coverage under the purchasing pool plan begins 10 days after the application has been determined complete.

Eligibility is determined once -- at time of application to the program-- and continues for 60 days post partum, for the mother and up to the child's ~~second~~ first birthday. Upon notification of birth, the infant will be enrolled in the Healthy Families Program. Prior to the child's first birthday, the Healthy Families Program will conduct an annual redetermination for the child's second year of coverage. Prior to the child's second birthday, the Healthy Families Program will redetermine eligibility for the S-CHIP Healthy Families Program. (~~However, the~~ The state seeks FFP ~~only~~ for the health care costs of the child up to age ~~one~~ two ~~and only~~ for children with family incomes between 200% and ~~250%~~ 300% of poverty.)

In California's state plan submission, we indicated that MRMIB would be using an application assistance fee of $50 which would be available to certain groups specified in MRMIB's regulations. These included child care centers, Parent-Teacher Associations (PTA's), and insurance agents and brokers, among others. The amount of $50 was obtained from the payment which MRMIB made for application assistance in two of its other programs (MRMIP – the high risk pool – and AIM). Originally, the fee had been set to reflect the cost for an agent or broker's assistance for application assistance and health plan selection. The fee assumed an agent/broker cost of approximately six percent of premiums, an amount which represented the low end of the agent reimbursement spectrum in the commercial market.

Since submission of the plan, MRMIB and DHS have concluded that it would be inconsistent with federal requirements to allow any of the application assistance fee-eligible entities to assist with health plan selection. As a sizeable portion of the $50 fee had included reimbursement for working with the applicant on health plan selection, DHS and MRMIB decided to reduce the fee.

Staff then assessed the cost of providing application assistance by a community-based organization (CBO). Assuming that the assistance would be provided by a paraprofessional staff person for 300 days per year, and would include four client interviews a day/site, an hour of travel, and two and a half hours/day for phone calls, administrative work, and technical assistance to other applicants, the cost/call would be $25.13. These costs are based on actual costs for the WIC program and do not include any time spent on assisting with health plan selection.

Thus, adjusting the application assistance fee to reflect the fact that assisters will not help applicants with health plan selection, MRMIB and DHS have set the fee to $25.

4.3.1. Describe the state's policies governing enrollment caps and waiting lists (if any). (Section 2106(b)(7)) (42CFR 457.305(b))

☐ **Check here if this section does not apply to your state.**

4.4. Describe the procedures that assure that:

4.4.1. Through the screening procedures used at intake and follow-up eligibility determination, including any periodic redetermination, that only targeted low-income children who are ineligible for Medicaid or not covered under a group health plan or health insurance coverage (including access to a state health benefits plan) are furnished child health assistance under the state child health plan. **(Sections 2102(b)(3)(A) and 2110(b)(2)(B)) (42 CFR 457.310(b) (42CFR 457.350(a)(1)) 457.80(c)(3))**

In the Medi-Cal program, California will implement a resource disregard for children in the Federal Poverty Level program. In the insurance programs, MRMIB will use income disregards similar to Medi-Cal's to ascertain whether a child should be a Medi-Cal or Healthy Families enrollee. Once it is clear that a child is not Medi-Cal eligible, his or her gross family income, will be reviewed to determine whether the child is Healthy Families eligible. Thus, the new insurance program and Medi-Cal will be substantially similar in terms of eligibility determination criteria.

DHS and MRMIB are developing a joint application for children's Medi-Cal and Healthy Families, and will add two questions on resources to the Medi-Cal only form of the joint application to assess whether children are eligible for the program because the State no longer performs an asset test. These questions do not provide sufficient information for identifying those children. We would suggest establishing a threshold amount above the Title XIX income eligibility, in which families within the threshold amount would then be asked qualifying questions beyond the two that were proposed, so as to further detail their resources. We believe this approach would provide you with the necessary information to properly account for the newly eligible children.

First, it is important to acknowledge that HCFA and California agree on the policy change that California has enunciated in the state plan -- implementing the resource disregard. The conversations we have had with HCFA have not been on whether to do it but how to document the amount for which California can claim enhanced FFP. In our view, this "how" question is an administrative issue which we can work out over time, and is not a policy issue which requires resolution before HCFA can approve our plan.

HCFA's request that California add additional resource questions to the Medi-Cal mail-in application form appears to be contradictory to HCFA's prior direction on this issue and to be at odds with our mutual goal of providing Medicaid coverage to children who meet eligibility criteria but who are not

enrolled. Further, we are concerned that there is some confusion on how our questions will work as they relate to eligibility for Medi-Cal.

With the resource disregard, a family's resources have no relevance in the determination of a child's eligibility. The sole use of this information is to determine which Medi-Cal costs are matchable at the enhanced rate due to expanded Medicaid coverage for federally targeted children who, heretofore, were not eligible for Medi-Cal. As the government agencies administering the Medicaid program, we need to be sensitive to and minimize the amount of information we require from the public. Without this sensitivity, we will continue to place unneeded barriers to families enrolling their children into Medicaid.

As we indicated in our original state plan submission and in our February 6, 1998, response to HCFA's questions, California is attempting to cover the estimated 400,000 children who meet Medi-Cal eligibility criteria but who are not enrolled. A key part of this effort to cover these children includes an aggressive effort to remove unnecessary questions from the current Medi-Cal application form, simplify the form, and allow it to be a mailed in. We believe this approach is consistent with the approach HCFA has taken in its model joint application for CHIP/Medicaid. This model application does not include any resource questions. This is validated by the examples of applications from other states that HCFA has provided, none of which include any resource questions. Further, HCFA in its "Discussion of Promising Outreach Strategies" advises states to "Streamline the eligibility process, have simplified application forms in appropriate languages, and allow application by mail. Ask only for necessary information."

It takes 35 questions on the Medi-Cal application to capture sufficient information on family resources. In the Healthy Families Program, California is implementing the resource disregard for certain Medi-Cal children. We did not want to ask any of these 35 questions for the sole purpose of claiming the enhanced federal match for these newly covered children. Instead, in our State Plan we proposed that we claim the enhanced match using a sampling approach. In the response to our State Plan, HCFA expressed concern over the legality of such a sampling approach and to date we have not heard resolution to this issue.

Given California's need to finalize our application to meet our July 1, 1998, implementation date, senior HCFA staff advised California to add two questions to our application to identify families who have resources that would have, heretofore, failed the resource test. Based upon HCFA's advice, California added these two questions to its form. One question asked if a family had more than one car and the other asked if the family had more than

$3,150 cash in a bank account (the asset limit). We agreed with HCFA staff that it was a reasonable way to document the number of children who would previously have been denied Medi-Cal because of family resource albeit, and one that would probably result in under claiming of the enhanced match. This is because the two questions will not detect all conditions where the State is entitled to enhanced match such as when a family would have failed the resource test due to excess stocks and bonds.

As you are aware, California's new application form has come under public and media criticism for its complexity. Beneficiary and children's advocacy groups have asked the State to justify each element of data on the form. When we have not had a valid reason, we have removed the data element. These groups expressed concern about the addition of the two resource questions worrying that families may (incorrectly) think that a positive answer would mean that they did not qualify for Medi-Cal. We are very concerned that now HCFA is proposing that California include detailed resource questions on our application. At the extreme, HCFA's position would require the addition of up to 33 more questions to the application. To get additional detail on the single car question we would have to add 10 more questions, including information on the make, model and registration of the car, and whether it is used for work transportation or self support.

In the request for information, HCFA indicates that we are adding two questions on resources to "...assess whether children are eligible for the program..." Further, HCFA suggests that we establish "...a threshold amount above the Title XIX income eligibility, in which families within the threshold amount would then be asked qualifying questions beyond the two that were proposed, so as to further detail their resources." This approach is illogical given California's approach to eligibility. In adopting a resource disregard, a family's income becomes the criterion for eligibility determination. If a family's income, less income deductions, meets the Medi-Cal income criteria (133% FPL for children one to six and 100% for children six to nineteen), these children would be eligible for Medi-Cal. All children in the proposed "threshold amount above the Title XIX income standard" would not be Medi-Cal eligible, but rather would enroll in Healthy Families. As Healthy Families has no resource test, it would be of no value to ask these families for their resources nor would this information make the family Medi-Cal eligible.

California has adopted HCFA's recommendation to add two questions to the application. As discussed with HCFA, these questions should capture the vast majority of cases in which disregard of resources has allowed children to become Medi-Cal eligible. Adding questions would detract from our mutual goal of reducing barriers to providing Medicaid coverage to currently eligible children with little overall value added. We request that HCFA remove its

request that California add more questions to its simplified application form. Alternatively, we again propose the use of a sampling methodology if that approach is deemed preferable to HCFA.

Resource Disregard. California will follow federal law that precludes certain income from being counted in determining eligibility for federally means tested programs and will not count this income. In determining Healthy Families eligibility, California will not count income from the following sources:

- Disaster Relief Payments (federal disaster and emergency assistance and comparable assistance provided by State and local governments and disaster assistance organizations;
- Per capita payments to Native Americans from proceeds held in trust and/or arising from use of restricted lands;
- Agent Orange Payments;
- Title IV Student Assistance;
- Energy Assistance Payments to Low Income Families;
- Relocation Assistance Payments;
- Victims of Crime Assistance Payments;
- Spina Bifida Payments; and
- Any other federal income deduction required for a federal means tested program.

Some federal income deductions, such as Earned Income Tax Credit and Japanese Reparation Payments, apply only to certain federal programs and not all federally means tested programs, including Title XXI. In cases where the income deduction does not apply to Title XXI, this income will be counted.

Further, the Healthy Families program will share eligibility files with Medi-Cal on an ongoing basis to check for children enrolled in both programs. Additionally, a random sample of applications will be audited using the Income Eligibility Verification System (IEVS) on an on-going basis to verify that the incomes being reported were the incomes earned.

Private Coverage. The application will ask parents about their access to employer sponsored coverage. Children who have been covered under such

coverage in the prior 3 months will be determined ineligible.

COUNTY CHILDREN'S HEALTH INSURANCE PROGRAM

All county expansion programs included in this state plan amendment proposes to follow the same screening procedures at the initial and annual eligibility review as those followed in the Healthy Families Program. Rules on income disregards, resource disregards and the three month separation period from private coverage all apply to C-CHIP enrollees. Initial applications and annual review applications that include a child who is applying for C-CHIP coverage but who may be eligible for no cost Medi-Cal or the Healthy Families Program will be forwarded to the State's Single Point of Entry for processing.

AIM

The program serves women whose family income is too high for Medi-Cal and who do not have employer sponsored coverage. The AIM administrative vendor verifies the income eligibility of families by reviewing income information submitted by families, either the previous year's federal income tax forms or current year wage stubs. Families eligible for no-cost Medi-Cal are denied AIM enrollment. If a family indicates on the AIM application that it has coverage through an employer, that application is not approved.

4.4.2. The Medicaid application and enrollment process is initiated and facilitated for children found through the screening to be potentially eligible for medical assistance under the state Medicaid plan under Title XIX. (Section 2102)(b)(3)(B)) (42CFR 457.350(a)(2))

California is currently assessing whether it is possible to develop an application form which can be used both for Healthy Families and Medi-Cal for pregnant women and children. Until that form is developed (and its development determined to be feasible), such families will be notified of their potential eligibility for Medi-Cal and how to apply when their Healthy Families application is returned to them.

The state's outreach and community based organization activities will be coordinated between Medi-Cal and the insurance program. These efforts will aim to assist families in applying for the program under which they qualify, with a goal of directing families to the correct program at the point of first contact, in recognition that CBOs are often the health system's first contact with uninsured families with income under 200% FPL.

The state also intends to rely heavily on the state's CHDP program as an access point into coverage. CHDP providers will screen the children for eligibility into Medi-Cal or Healthy Families and assist families in filing applications for the appropriate program.

COUNTY CHILDREN'S HEALTH INSURANCE PROGRAM

Even though each of the C-CHIP's has created their own application, they were all modeled after the joint Medi-Cal/Healthy Families application, hence the C-CHIP applications contain the same questions and have the same look and feel. As a result, the State's Single Point of Entry processing center will have the necessary information to make an eligibility determination. Once a child is determined Healthy Families eligible, the applicant will be contacted for a health plan selection and first month's premium payment.

4.4.3. The State is taking steps to assist in the enrollment in SCHIP of children determined ineligible for Medicaid. **(Sections 2102(a)(1) and (2) and 2102(c)(2)) (42CFR 431.636(b)(4))**

Establishment of California's Single Point of Entry (SPE)

The SPE, run by the Healthy Families administrative vendor, was established to 1) create a centralized location for the joint mail-in Healthy Families/Medi-Cal for Children applications to be received; and, 2) screen eligible children to Healthy Families or Medi-Cal as appropriate. The benefits that have resulted from the State's SPE are assuring compliance with the federal screen and enroll requirement, applying consistent eligibility criteria when conducting the Medi-Cal eligibility screen; streamlined application and enrollment process for families, and a central point of contact for county eligibility workers.

Application Process:

Applicants mail the joint mail-in application directly to the SPE. The SPE first screens all applications for no-cost Medi-Cal eligibility, and then routes the applications to either the County Welfare Department (CWD) or HFP as appropriate.

When applications are sent to Medi-Cal from the SPE and the children are determined to be ineligible for no-cost Medi-Cal due to income considerations or updated information, the CWD returns the application to the SPE with a transmittal form to indicate why the person is ineligible for no-cost Medi-Cal. The SPE has on-site liaison staff that is proficient in Medi-Cal eligibility criteria and can evaluate whether the information received or forwarded from

the county is sufficient to forward directly to HFP. The SPE liaison staff work directly with county staff on those applications in which the information forwarded to the SPE is not sufficient to support a definitive eligibility determination. This quality improvement effort has increased the standardization of eligibility determinations and reduced the unnecessary flow of applications between programs.

The State has further streamlined the enrollment process by providing alternatives to the standard joint mail-in application. A Medi-Cal application (MC 210) or the Medi-Cal Annual Redetermination form with a Notice of Action (NOA) and supporting documentation, is acceptable for use as an application for the HFP. Consistent with this policy, DHS has issued a letter, which instructs counties to forward the applications of no-cost Medi-Cal ineligible persons to the HFP. Applications that are initiated at or mailed to the county directly and determined to have children ineligible for no-cost Medi-Cal because income exceeding the Medi-Cal limits are forwarded to the SPE for a HF determination. These applications are forwarded with a transmittal form, NOA, and supporting documentation as available.

Medi-Cal Redetermination Process:

At the time of a Medi-Cal redetermination, if a child is determined to no longer be eligible for no-cost Medi-Cal because of income, the CWD forwards a transmittal, notice of action, and the supporting documentation to the HFP for a determination. Moreover, the SPE, MEDS, and the HFP administrative vendor's internal data systems interface. If a Medi-Cal or HFP enrollee has an income change before his/her redetermination and requests a redetermination to establish eligibility for the other program, each program has the ability to forward (or receive) information and supporting documentation. This information and process can be used to establish eligibility and maintain seamless health coverage.

Since the HFP's inception, the State has provided a "one-month bridge" which is a transition period for those children living in families with incomes that no longer qualify them for no-cost Medi-Cal. The one-month bridge continues the child's coverage for an additional month while the HPF makes an eligibility determination and the child is enrolled. Each person enrolled in a Medi-Cal health plan will continue his or her enrollment in the same health plan during the one-month bridge.

4.4.4. The insurance provided under the state child health plan does not substitute for coverage under group health plans. Check the appropriate box. (Section 2102)(b)(3)(C)) (42CFR 457.805) (42 CFR 457.810(a)-(c))

California will include provisions to minimize the potential for employers or individual employees do not drop their current dependent coverage to take advantage of subsidized coverage. Such "crowd out" seems to be a potential consequence of making available subsidized coverage for children. However, given that several researchers have found that crowd out is not a serious concern when subsidized programs are limited to children, the state is not sure how big a danger crowd out might actually be.[4]

Nonetheless, we believe that the measures we have adopted in our authorizing statute are among the best approaches to prevent crowd out. Features to avoid crowd out include:

- Establishes a coverage "firewall" -- a prohibition against covering children who have had employer sponsored coverage within 3 months prior to applying for Healthy Families. MRMIB is authorized to increase the length of the period to 6 months if it finds that Healthy Families is covering substantial numbers of children who were previously covered under employer-sponsored plans.

- The state has established exceptions to this limitation in cases where prior coverage ended due to reasons unrelated to the availability of the Program. These include, but are not limited to:

  - Loss of employment due to factors other than voluntary termination.
  - Change to a new employer that does not provide an option for dependent coverage.
  - Change of address so that no employer sponsored coverage is available.
  - Discontinuation of health benefits to all employees of the applicant's employer.
  - Expiration of COBRA coverage period.
  - Coverage provided pursuant to an exemption authorized under subdivision (I) of Section 1367 of the Health and Safety Code.

- Establishes copayments for non-preventive services.

- Prohibits insurance agents and insurers from referring dependents to the program where dependents are already covered through employer

4 See Chollet, Deborah J., Birnbaum, Michael and Sherman, Michael J. of the Alpha Center, "Deterring Crowd-Out in Public Insurance Programs: State Policies and Experience" (October 1997); Children's Defense Fund, "Fears That Employers Coverage Will Fall If Uninsured Children Are Helped Are Exaggerated" (November 1997); and Center for Health System Change *Issue Brief No. 3*, "Medicaid Eligibility Policy and the Crowding-Out Effect" (October 1996).

sponsored coverage. Violation of the provisions would constitute unfair competition under the Business and Professions Code.

- Makes it an unfair labor practice for an employer to refer employees to the program for dependent coverage where the employer provides for such coverage.

- Makes it an unfair labor practice for an employer to change coverage or change the employee share of cost for coverage to get employees to enroll in the Program.

- Directs MRMIB to develop participation standards that minimize "crowd out".

- Directs MRMIB to monitor applications to determine whether employers or employees dropped coverage to participate in the program.

MRMIB will monitor applications to determine whether employers or employees have dropped coverage to participate in the program. Specific monitoring strategies that the Board will consider include the use of a third party evaluator, and subscriber or employer surveys to measure the extent to which crowd-out has occurred.

The state is aware that HCFA is developing a crowd out policy and would be interested in commenting on that policy before it is adopted. HCFA should be aware that California, like many states, has adopted state legislation based upon the federal law giving states broad authority. We ask that HCFA keep in mind the impact of any such policy on state law and the state's commitment to make Healthy Families' coverage to uninsured children by July 1, 1998. Furthermore, California notes that the federal statute authorizing the "State Children's Health Insurance Program" does not provide the U.S. Department of Health and Human Services the authority to require states to meet national crowd out standards as a condition of eligibility for federal funds. While California is committed to remaining a leader in the development and use of strategies to avoid crowd out, each state should be allowed to set its own crowd out strategies without interference from Washington.

Exceptions. We would also like to raise with HCFA an issue that the State believes could exacerbate crowd out. The State believes that uninsured children have a high, unmet need for dental services. For example, the most frequent medical need identified in health screens done in our Child

Health and Disability Prevention Program (EPSDT for uninsured children with incomes above Medi-Cal levels) is dental services.

The State believes that an additional important crowd out mitigation measure would be to allow children with health coverage – but no dental or vision coverage – to buy dental and vision coverage through the program. We are aware that children with health coverage are ineligible for the Title XXI funded programs. However, permitting families to remain in their employer-based coverage while accessing the HFP dental and vision benefits could be an important mechanism for discouraging parents of children with little or no vision or dental coverage from dropping the employer-sponsored health care in order to access such benefits through the Healthy Families Program benefit package. We want to raise this issue to you as your consider any possible legislative changes to Title XXI or possible Title XXI waivers.

COUNTY CHILDREN'S HEALTH INSURANCE PROGRAM

The C-CHIPs will adopt the same provisions as the Healthy Families Program to minimize the potential for employers or individual employees to drop their current dependent coverage to take advantage of subsidized coverage.

4.4.4.1. ☑ **Coverage provided to children in families at or below 200% FPL: describe the methods of monitoring substitution.**

4.4.4.2. ☑ **Coverage provided to children in families over 200% and up to 250% FPL: describe how substitution is monitored and identify specific strategies to limit substitution if levels become unacceptable.**

4.4.4.3. ☐ **Coverage provided to children in families above 250% FPL: describe how substitution is monitored and identify specific strategies in place to prevent substitution.**

4.4.4.4. ☐ **If the state provides coverage under a premium assistance program, describe:**

The minimum period without coverage under a group health plan, including any allowable exceptions to the waiting period.

The minimum employer contribution.

The cost-effectiveness determination.

4.4.5. Child health assistance is provided to targeted low-income children in the state who are American Indian and Alaska Native. **(Section 2102)(b)(3)(D)) (42 CFR 457.125(a))**

The provision of child health assistance to low income children who are American Indians (as defined in section 4(c) of the Indian Health Care Improvement Act, 25 U.S.C.1603(c) (Section 2102)(b)(3)(D) or who are Alaska Natives (as defined in the Alaska Native Claims Settlement Act, 43 U.S.C. 1601), will be assured through the following procedures:

- Technical assistance by the state American Indian Health Program, Federal Indian Health Services, and tribes in tracking of services to American Indians.

- Inclusion of American Indian ethnicity using the federal definition on the application form for tracking purposes.

- Targeted statewide outreach media campaign and outreach activities through contracts with selected community based organizations providing services to American Indian children to assure that American Indian families are aware of the program throughout the state and to assist children in enrolling in the Healthy Families Program.

- Provision of training to local American Indian clinic staff for outreach and referral to the Healthy Families program.

- Use of the 30 American Indian primary care clinics (which are CHDP providers) to screen low income youth, provide initial treatment and referral either to Medi- Cal or Healthy Families.

- Provision to exempt American Indian and Alaska Native families, that meet the cost sharing waiver requirements, from monthly premiums and benefit copayments. This exemption will be made only when an AI/AN provides acceptable documentation showing proof of his/her AI/AN status. Acceptable documentation for the applicant or the child includes:

    1. An American Indian or Alaska Native enrollment document from a federally recognized tribe; or

2. A Certificate Degree of Indian Blood (CDIB) from the Bureau of Indian Affairs; or
3. A Certificate of Indian Heritage from an Indian Health Service facility operating in the State of California.

Section 5. Outreach (Section 2102(c))

Describe the procedures used by the state to accomplish:

Outreach to families of children likely to be eligible for child health assistance or other public or private health coverage to inform them of the availability of the programs, and to assist them in enrolling their children in such a program:
(Section 2102(c)(1)) (42CFR 457.90)

The state recognizes the importance of outreach to families of children likely to be eligible for assistance under the Healthy Families Program to inform families of the availability of coverage and to motivate them to enroll. California will undertake a multifaceted approach to outreach to meet these goals. California will secure a $20 million annual outreach contract with a private entity, which will conduct a media campaign and subcontract with community based organizations and other entities to directly identify and assist potential enrollees to Medi-Cal and the new Healthy Families insurance program. The state will also use a pre-enrollment process and application assistance fee to outreach to beneficiaries, as well as reduce barriers such as complicated enrollment forms which may impede beneficiaries from participating. In addition, California will engage in a provider education effort in support of its outreach campaign, as providers are a vital link to the subscriber community. California believes this multi-pronged outreach strategy will motivate the families of targeted low income children to enroll them into the subsidized health insurance programs that California has available to them.

The Department of Health Services (DHS) is recognized nationally as a leader in social marketing and public awareness campaigns and will be responsible for outreach for both the Medi-Cal and Healthy Families' insurance programs. Pursuant to Section 14067 of the Welfare and Institutions Code, DHS will develop and conduct a community outreach and education campaign to help families learn about and apply for Medi-Cal and the newly authorized health insurance program. The outreach campaign will target families of children who are currently eligible for Medi-Cal but not enrolled in the program, as well as targeted low income children who will be newly eligible for the Healthy Families Program. DHS will administer the outreach contract because of its extensive experience conducting similar outreach efforts, including the BabyCal campaign which focuses on prenatal care for both, the Medi-Cal and AIM programs, the statewide anti-tobacco campaign, and the Partnership for Responsible Parenting which aims to reduce teen and unwed pregnancy.

The outreach efforts for the Healthy Families and Medi-Cal programs will be modeled after similar Departmental campaign efforts such as BabyCal. Under BabyCal, DHS conducts education and outreach programs to low- income pregnant women who may be eligible either for Medi-Cal or AIM. DHS targets its message to low-income

uninsured women who are then referred to the appropriate program. DHS will also rely on its experience conducting beneficiary education and outreach for its Medi-Cal managed care efforts, including the importance of using materials and messages that are appropriate to the target populations' comprehension levels, languages, and cultures.

DHS and MRMIB are committed to meeting the requirements of Title VI of the Civil Rights Act of 1964 by ensuring that non-English speaking persons are included in outreach, media and enrollment activities. Below we describe how DHS will address outreach to non-English speaking populations and how MRMIB will address access to enrollment materials for these populations.

DHS Outreach & Media Contractor

DHS will contract with a private marketing firm to administer the statewide outreach campaign. Outreach efforts will consist of two main strategies to enroll uninsured children into the Title XXI funded programs as quickly as possible. The first is a traditional multi-media approach. DHS will implement a variety of targeted outreach strategies, such as English and Spanish advertising on TV, radio, outdoor billboards, transit ads, posters, pamphlets, fliers, and other promotional items. Additionally, collateral materials in ten threshold languages will be printed and distributed, and the state may incorporate additional threshold languages into the media campaign as the program matures. California will also use print media to educate providers who are a key link to the target population.

The outreach message will be simple. The target population will be informed about the importance of preventive care, the value of insuring children before they become ill and that health care programs for the uninsured are available. Potential beneficiaries will be advised to call a toll-free phone number for more information. DHS has used a similar approach though its administration of the BabyCal campaign, a $6 million annual effort which educates pregnant women of the importance of prenatal care. The DHS' toll free line directs low and modest income pregnant women to Medi-Cal or to the Access for Infants and Mothers (AIM) Program to assist them in obtaining coverage for their pregnancies. The multi-media approach is intended to effectively and quickly notify the broad public about Healthy Families and Medi-Cal's availability to cover children.

The second facet of the outreach strategy is a community outreach effort to complement the statewide media campaign. The community outreach effort will entail distribution of print material and promotional items developed under the media component as well as work at the individual level to explain to families what must be done to obtain health insurance and all steps needed to see a health care provider. The DHS outreach contractor will coordinate a number of community-based initiatives to

educate potentially eligible applicants about the program and to assist potential applicants in the application process, and will partner with entities working directly with target populations. The existing infrastructure of public health programs already serves a high proportion of families with targeted low income children, as do other entities such as community-based organizations and schools. Thus, in overseeing the campaign, DHS will coordinate with, seek input from, offer comprehensive training to, and partner with entities and programs including (but not limited to): MRMIB and its contracting health plans; the California Department of Education; county health departments; Women, Infants, and Children (WIC) program agencies; Child Health and Disability Prevention (CHDP) providers; primary care clinics; school-linked health services, such as Head Start and Healthy Start programs; and community based organizations that deal with potentially eligible families and children.

Community based organizations, public health programs, and other entities will play a key role in the state's outreach and education efforts given their community orientation and focus, as well as their ability to provide culturally and linguistically appropriated services to California's diverse target population. Furthermore, these programs and organizations are a vital link to families of targeted low income children who may not be otherwise reached through the statewide media campaign, such as farm worker families and immigrant communities, among others. By allocating a significant portion of its outreach resources to this local effort, California will better ensure that it educates potential beneficiaries from diverse cultural and ethnic populations in the state, and will target families that -- through a media campaign alone -- may not be motivated to enroll in the Healthy Families insurance program or in Medi-Cal.

In implementing the Outreach and Media contracts for both Medi-Cal and Healthy Families, DHS, through its outreach and media contractor, RS&E, will:

- Translate the joint Medi-Cal/Healthy Families application pamphlet into ten threshold languages: English, Spanish, Cantonese, Russian, Farsi, Cambodian, Laotian, Hmong, Vietnamese, and Armenian. Counties with high populations in other languages will do further form translations as they currently do for the existing Medi-Cal form;
- Maintain a toll-free outreach number with operators who speak English and Spanish and who have access to the AT&T translation services for all other languages;
- Place outdoor advertising in the threshold languages wherever at least 1,000 Medi-Cal recipients in a given zip code speak one of the languages.
- Develop outreach print materials in the ten threshold languages, including material to be published in newspapers and periodicals published in the ten threshold languages;
- Conduct radio and TV spots in English and Spanish; and

- Recruit a diverse cultural, linguistic and geographic mix of CBO's to assist applicants, focusing particularly on those with an existing relationship with subpopulations of the target group. The CBO's will help ensure that the target populations can access program information and assistance.

Healthy Families Administrative Vendor

MRMIB is aware that its program needs to serve the linguistic and cultural needs of California's diverse population. In fact, MRMIB anticipates that as many as 60 percent of children who will be served by Healthy Families will be Latino. The Model Contract for the administrative vendor requires the vendor to:

- Describe how the organization will approach communicating effectively with a linguistically diverse population;
- Print Health Families specific information included in the application packet (the joint application and Healthy Families brochure) in the 10 threshold languages;
- Translate all Healthy Families Program materials into ten Medi-Cal threshold languages in year one. MRMIB will reevaluate this strategy during the program's second year to assess if Medi-Cal's threshold languages are appropriate for Healthy Families;
- Maximize the availability of non-English written materials, per the requirements of Section 7290 of the Government Code. This statute requires that a state agency make non-English languages available to the extent that 5 percent or more the population being served speaks a particular language. The Board's review of the primary languages spoken by the 113,117 statewide share-of-cost Medi-Cal enrollees between the ages of 1-18 during the sample month of January, 1998, shows the following: English, 52,062; Spanish, 55,585, Vietnamese, 1,567; Cantonese, 1,225; Tagalog, 423; Korean and Russian, 217 each; Hmong and Laotian, 128. Based on this review, the Board's administrator would publish materials in English and Spanish. The Board has decided to exceed the requirements of Government Code Section 7290, at least for the first year;
- Assure that all translated materials are an accurate and culturally sensitive translation of the English version. The vendor must have two independent readers verify the accuracy of each translation. The contract specifies that the vendor must have application package and other materials available in all threshold languages by June 1, 1998 or be subject to liquidated damages;
- Have trained English and Spanish speaking staff on site between 8 AM and 8 PM weekdays and have the capability to provide telephone services via a translation service for all other languages in the threshold languages identified above; and
- Establish a Network Information Service for subscribers which, among other

data, will list languages spoken at each provider's office.

Overall, in its oversight of the outreach contract, DHS is committed to the following:

- Focus group testing to ensure quality and understanding of communication materials with target population.

- Ongoing and frequent involvement of stakeholders. Such stakeholders include, but are not limited to: community based organizations (CBO's), members of the target population, providers, public health programs, advocacy groups, and the Department of Social Services, which is leading the State's welfare reform efforts.

- Development of linguistically appropriate informing materials in up to ten threshold languages as appropriate.

The collaborative strategy to initiate a large state-wide media campaign with significant emphasis on local community-based involvement will effectively spread the message that:

- 1) preventive services like those provided through comprehensive, child focused health insurance is important to keep children healthy; and

- 2) California has programs, like Medi-Cal and Healthy Families, which can help families become a part of a medical home.

Beyond administering the outreach contract, DHS will ensure that staff at the state and county level will be well trained to respond to inquiries from and provide progress reports to CBO's, advocacy groups, the legislature, and other interested parties, to enroll eligible children, and to ensure that providers are involved early on in the process. In addition, outreach efforts will be coordinated with existing state efforts to outstation eligibility workers at federally qualified health centers (FQHC's) and disproportionate share hospital (DSH) facilities.

The outreach effort will also be targeted to business coalitions, such as the Chamber of Commerce, to ensure that employees are aware of the new programs for uninsured children. Messages to employers will emphasize that the programs are for children presently uninsured and will detail the various statutory sanctions (described in Section 4.4.4) to deter employers from dropping dependent coverage.

While DHS will undertake the efforts outlined above, MRMIB will conduct a number of corresponding efforts to outreach to uninsured families whose children may be eligible for the insurance program. MRMIB will begin by starting a pre-enrollment

process. From now until the program begins, MRMIB will be keeping a list of all potential beneficiaries who contact them expressing interest about the program. When all enrollment materials become available, MRMIB will mail enrollment materials to all applicants on their mailing list.

To complement the media campaign, the State will fund an extensive grass roots outreach effort using pay for performance reimbursement of local individuals and entities. The grass roots effort is based on a "people helping people" model in which a broad range of individuals and entities are trained to assist families with the joint Medi-Cal/Healthy Families application.

Funding for application assistance fees paid to CBO's will come from DHS. Funding of fees paid to health care providers and insurance agents will come from MRMIB. All funds will be administered through Runyon, Saltzman & Einhorn (RS&E). Through RS&E, training sessions and continuing education courses will be offered to representatives of local entities. These community organizations include local health departments, licensed day care operators, schools, faith based organizations, community clinics, and insurance agents. The training will provide participants with skills in assisting families to complete the joint application.

Upon successful completion of the training, the representatives of the organizations will be authorized to conduct training sessions with other persons in their organization. The organization's trainer will have to certify which employees have completed the training and attest to understanding program rules and regulations. Agent/brokers can be trained via a course for which continued education units (CEU's) are available. RS&E will develop the curriculum for the training as well as conducting the training sessions.

Once a person is certified as trained, he or she is eligible to assist applicants (for both Medi-Cal and Healthy Families) and bill for the assistance fee. The fee will only be paid after verification of enrollment. The fee will be paid no more often than once for any child/family in any given twelve month period and will also be available for case assistance provided during the annual requalification.

When a CBO, provider, or agent's bills for the $25, the person providing the assistance will sign a certification that they did not assist the family in health plan selection nor violate any of the State's other requirements. In the Medi-Cal program, conflict of interest is not problematic because choice of health plan is an entirely separate process that occurs after eligibility has been determined by the county. The joint application form being developed for Medi-Cal and Healthy Families contains an item for designation of health plan for the Healthy Families Program portion of the application exclusively. Further, since the state will be requiring the assisters to certify that they understand program rules and regulations, the state will be able to

prosecute any assister that does make plan recommendations.

DHS will establish an outreach working group to advise RS&E, the Department, and MRMIB on the efficacy of its outreach and education strategy. Healthy Families will monitor program experience to ensure compliance with program rules, particularly those related to conflict of interest, by having the administrator ask the applicant at the time of the welcome call (10 days after enrollment) whether anyone attempted to refer the applicant to a given health plan. In addition, DHS and MRMIB will assess the experience of this approach over time to determine if it is meeting its goals of facilitating the enrollment of eligible families into Healthy Families and Medi-Cal. Finally, we would note that a Medi-Cal specific outreach and education effort, focused on children who are uninsured but Medi-Cal eligible, will be conducted. This campaign will operate under the same principles and strategies as the Healthy Families Program campaign.

In addition to pre-enrollment, MRMIB may also provide a $50 one-time application assistance fee for entities and individuals that assist beneficiaries applying for the Healthy Families Program. MRMIB successfully uses an application assistance fee in two of its existing programs, MRMIP and AIM. The purpose of the fee is to provide an outcomes based financial incentive to organization/person who come into regular contact with the target population. Use of the application assistance fee is particularly important as it is the way by which MRMIB creates an incentive to encourage participation from a large number of community organizations who have contact with uninsured children.

MRMIB will pay the application assistance fee only for those beneficiaries who are successfully enrolled into the insurance program. Such entities, which are certified by MRMIB, are broadly defined as groups which have potential outreach capabilities to educate and enroll targeted applicants into the Healthy Families Program. They include, but are not limited to, Parent Teacher Associations, insurance agents and brokers, WIC clinics, community clinics, and county welfare departments. MRMIB certifies entities and individuals who are able to collect the application assistance fee, to ensure proper oversight of the efforts and avoid potential marketing abuses associated with the fee. Providing a $50 assistance fee will give entities an incentive to inform, educate, and help enroll all potential beneficiaries.

In creating the Healthy Families state plan, the state is making an extensive effort to reach out to and receive input from the public. Comments and suggestions made by various public agencies have helped California to develop and shape its outreach strategies. The Health and Welfare Agency hosted two forums in October to receive input from the public on implementation of the Healthy Families Program. In addition to the open forums, DHS conducted a series of meetings with stakeholder groups to obtain input on Healthy Families outreach efforts. The groups included community-

based organizations, counties, program agencies, advocates, health plans, and providers. These meetings have helped create an open dialogue between interested parties on this important issue of mutual concern.

In a similar vein, MRMIB holds bi-monthly public meetings to solicit public input in its decision-making process for Healthy Families, and will use a 14 member Advisory Board to receive further constructive feedback. MRMIB mails out drafts of regulations and model contracts to its extensive mailing list and solicits public testimony on the drafts prior to finalizing them. Throughout the implementation process, DHS and MRMIB will continue communication with interested groups to solicit feedback pertaining to California's outreach efforts.

One consistent theme that has emerged from public discussions thus far is the importance of reducing barriers to enrollment as a means of conducting outreach. In the past, long and complex forms may have intimidated and deterred potential applicants from enrolling in state health insurance programs. To ensure the greatest amount of applicants will enroll in either the state's Medi-Cal or new insurance programs, all application materials will be simplified to make the process as easy and "applicant friendly" as possible. Recognizing that documenting assets for the purposes of determining eligibility for Medi-Cal is time consuming and burdensome for many applicants, and thus may act as a barrier to enrollment, California will disregard resources for children in the Medi-Cal federal poverty level programs. This allows DHS to significantly simplify the Medi-Cal application for children. Like the AIM program, MRMIB will also use a simple mail-in application for the new insurance program. Furthermore, DHS and MRMIB are in the process of determining whether a joint application between Medi-Cal and the new Healthy Families insurance program will simplify the application and enrollment procedure.

Another matter of importance is the development of outreach and enrollment materials that are appropriate to the populations' reading comprehension levels, languages, and cultures.

DHS will create a toll free number to increase public awareness about Medi-Cal and the new insurance program. To ensure that this toll free line is accessible to the broadest array of Californians, DHS is exploring the use of multi-lingual prompts and operator assistance to help facilitate easier access to information and services. To ensure that application and enrollment materials are understandable to the target population, DHS will use the entity which has assisted in the development and translation of enrollment material for Medi-Cal managed care.

Finally, public affairs officials of both DHS and MRMIB will provide information to health care providers, business coalitions and other targeted groups about the new health insurance programs by submitting brief program descriptions and

implementation time lines in various magazines, bulletins, and journals. For example, the December 1997 Medi-Cal Quarterly Newsletter and the January 1998 Medi-Cal Monthly Bulletin will have articles featuring the Healthy Families program. The State of California will feature key aspects of the Healthy Families Program on its state home page on the Internet, and MRMIB will require that its administrative vendor establish and maintain a Healthy Families web site. This will provide the general public an overview of the new policy, specific programs within Healthy Families, and contact names and locations for more detailed information, complementing the comprehensive outreach efforts under the outreach contractor.

Outreach Time Line:

October 1997:	Begin public comment on regulations
November 1997:	Release RFP for outreach contractor
December 1997:	Release of Medi-Cal quarterly newsletter
January 1998:	Initial release of monthly Medi-Cal bulletin
February 1, 1998:	Award contracts to outreach contractor
February 1, 1998:	Toll free information launched
February 18, 1998:	Radio, collateral and outdoor advertising launched
March 1, 1998:	Medi-Cal enhancements in place (resource disregard, 100% expansion)
June 1, 1998:	Program enrollment materials available
June 1, 1998:	Medi-Cal enhancement in place (one month continued eligibility)
July 1, 1998:	First children enrolled in insurance program

*MRMIB's pre-enrollment process occurs from now until enrollment begins.

COUNTY CHILDREN'S HEALTH INSURANCE PROGRAM

The local C-CHIP will use state trained application assistants at community organizations, county welfare staff and the Healthy Families Program to "get the word out" about the availability of the C-CHIP. Application assistants in the community today are aware of the county sponsored programs and currently provide assistance in getting children enrolled in the programs. The Healthy Families administrative vendor has been provided with phone scripts that identify counties with expansion programs in order to refer families to if they are residents of that county and are ineligible for the Healthy Families Program because of excess income. We are in the process of modifying procedures with the Healthy Families administrative vendor to request the families' permission to forward these applications to the local programs.

Section 6. Coverage Requirements for Children's Health Insurance (Section 2103)

☐ **Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan, and continue on to Section 7.**

6.1. The state elects to provide the following forms of coverage to children: (Check all that apply.) (42CFR 457.410(a))

6.1.1. ☐ Benchmark coverage; (Section 2103(a)(1) and 42 CFR 457.420)

6.1.1.1. ☐ FEHBP-equivalent coverage; (Section 2103(b)(1)) (If checked, attach copy of the plan.)

6.1.1.2. ☑ State employee coverage; (Section 2103(b)(2)) (If checked, identify the plan and attach a copy of the benefits description.)

California will use the CalPERS state employee benefit package as the benchmark coverage for health. It will provide enhanced services beyond the benchmark package, including comprehensive dental and vision coverage, screening and initial treatment services through the CHDP program and treatment services for severely ill children in a non-managed care delivery system. For a full benefits description, see Attachment 6.

COUNTY CHILDREN'S HEALTH INSURANCE PROGRAM

The C-CHIPs will provide the same comprehensive benefit package as that of the Healthy Families Program, with a few exceptions, to its enrollees. The exceptions to the benefit package include:

- The covered CHDP services received prior to Healthy Families enrollment will not be included in C-CHIP.
- Children enrolled in C-CHIP and diagnosed with a CCS eligible condition will be referred to CCS for a full eligibility determination. If the child is determined CCS eligible, CCS will provide services to treat the CCS condition. If the child is not CCS eligible, the health plan shall provide all medically necessary services including the treatment of the CCS condition as is true under the benchmark coverage.

6.1.1.3. ☐ **HMO with largest insured commercial enrollment** (Section 2103(b)(3)) **(If checked, identify the plan and attach a copy of the benefits description.)**

6.1.2. ☐ **Benchmark-equivalent coverage;** (Section 2103(a)(2) and 42 CFR 457.430) **Specify the coverage, including the amount, scope and duration of each service, as well as any exclusions or limitations. Please attach a signed actuarial report that meets the requirements specified in 42 CFR 457.431. See instructions.**

6.1.3. ☐ **Existing Comprehensive State-Based Coverage;** (Section 2103(a)(3) and 42 CFR 457.440) **[Only applicable to New York; Florida; Pennsylvania] Please attach a description of the benefits package, administration, date of enactment. If existing comprehensive state-based coverage is modified, please provide an actuarial opinion documenting that the actuarial value of the modification is greater than the value as of 8/5/97 or one of the benchmark plans. Describe the fiscal year 1996 state expenditures for existing comprehensive state-based coverage.**

6.1.4. ☐ **Secretary-Approved Coverage.** (Section 2103(a)(4)) (42 CFR 457.450)

6.1.4.1. ☐ **Coverage the same as Medicaid State plan**
6.1.4.2. ☐ **Comprehensive coverage for children under a Medicaid Section 1115 demonstration project**

6.1.4.3. ☐ **Coverage that either includes the full EPSDT benefit or that the state has extended to the entire Medicaid population**
6.1.4.4. ☐ **Coverage that includes benchmark coverage plus additional coverage**
6.1.4.5. ☐ **Coverage that is the same as defined by existing comprehensive state-based coverage**
6.1.4.6. ☐ **Coverage under a group health plan that is substantially equivalent to or greater than benchmark coverage through a benefit by benefit comparison (Please provide a sample of how the comparison will be done)**
6.1.4.7. ☐ **Other (Describe)**

6.2. **The state elects to provide the following forms of coverage to children: (Check all that apply. If an item is checked, describe the coverage with respect to the amount, duration and scope of services covered, as well as any exclusions or**

limitations) **(Section 2110(a))** **(42CFR 457.490)**

6.2.1. ☐ **Inpatient services** **(Section 2110(a)(1))**

6.2.2. ☐ **Outpatient services** **(Section 2110(a)(2))**

6.2.3. ☐ **Physician services** **(Section 2110(a)(3))**

6.2.4. ☐ **Surgical services** **Section 2110(a)(4))**

6.2.5. ☐ **Clinic services (including health center services) and other ambulatory health care services.** **(Section 2110(a)(5))**

6.2.6. ☐ **Prescription drugs** **(Section 2110(a)(6))**

6.2.7. ☐ **Over-the-counter medications** **(Section 2110(a)(7))**

6.2.8. ☐ **Laboratory and radiological services** **(Section 2110(a)(8))**

6.2.9. ☐ **Prenatal care and pre-pregnancy family services and supplies** **(Section 2110(a)(9))**

6.2.10. ☐ **Inpatient mental health services, other than services described in 6.2.18., but including services furnished in a state-operated mental hospital and including residential or other 24-hour therapeutically planned structural services** **(Section 2110(a)(10))**

6.2.11. ☐ **Outpatient mental health services, other than services described in 6.2.19, but including services furnished in a state-operated mental hospital and including community-based services** **(Section 2110(a)(11)**

6.2.12. ☐ **Durable medical equipment and other medically-related or remedial devices (such as prosthetic devices, implants, eyeglasses, hearing aids, dental devices, and adaptive devices)** **(Section 2110(a)(12))**

6.2.13. ☐ **Disposable medical supplies** **(Section 2110(a)(13))**

6.2.14. ☐ **Home and community-based health care services (See instructions)** **(Section 2110(a)(14))**

6.2.15. ☐ **Nursing care services (See instructions)** **(Section 2110(a)(15))**

6.2.16. ☐ **Abortion only if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest** **(Section 2110(a)(16)**

6.2.17. ☐ **Dental services** (Section 2110(a)(17))

6.2.18. ☐ **Inpatient substance abuse treatment services and residential substance abuse treatment services** (Section 2110(a)(18))

6.2.19. ☐ **Outpatient substance abuse treatment services** (Section 2110(a)(19))

6.2.20. ☐ **Case management services** (Section 2110(a)(20))

6.2.21. ☐ **Care coordination services** (Section 2110(a)(21))

6.2.22. ☐ **Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders** (Section 2110(a)(22))

6.2.23. ☐ **Hospice care** (Section 2110(a)(23))

6.2.24. ☐ **Any other medical, diagnostic, screening, preventive, restorative, remedial, therapeutic, or rehabilitative services. (See instructions)** (Section 2110(a)(24))

6.2.25. ☐ **Premiums for private health care insurance coverage** (Section 2110(a)(25))

6.2.26. ☐ **Medical transportation** (Section 2110(a)(26))

6.2.27. ☐ **Enabling services (such as transportation, translation, and outreach services (See instructions)** (Section 2110(a)(27))

6.2.28. ☐ **Any other health care services or items specified by the Secretary and not included under this section** (Section 2110(a)(28))

6.3. The state assures that, with respect to pre-existing medical conditions, one of the following two statements applies to its plan: (42CFR 457.480)

6.3.1. ☑ **The state shall not permit the imposition of any pre-existing medical condition exclusion for covered services** (Section 2102(b)(1)(B)(ii)); **OR**

6.3.2. ☐ **The state contracts with a group health plan or group health insurance coverage, or contracts with a group health plan to provide family coverage under a waiver (see Section 6.4.2. of the template). Pre-existing medical conditions are permitted to the extent allowed by HIPAA/ERISA** (Section 2103(f)). **Please describe:**

Previously 8.6

6.4. Additional Purchase Options. If the state wishes to provide services under the plan through cost effective alternatives or the purchase of family coverage, it must request the appropriate option. To be approved, the state must address the following: **(Section 2105(c)(2) and(3)) (42 CFR 457.1005 and 457.1010)**

6.4.1. ☐ Cost Effective Coverage. Payment may be made to a state in excess of the 10% limitation on use of funds for payments for: 1) other child health assistance for targeted low-income children; 2) expenditures for health services initiatives under the plan for improving the health of children (including targeted low-income children and other low-income children); 3) expenditures for outreach activities as provided in section 2102(c)(1) under the plan; and 4) other reasonable costs incurred by the state to administer the plan, if it demonstrates the following **(42CFR 457.1005(a))**:

6.4.1.1. Coverage provided to targeted low-income children through such expenditures must meet the coverage requirements above; Describe the coverage provided by the alternative delivery system. **The state may cross reference section 6.2.1 - 6.2.28. (Section 2105(c)(2)(B)(i)) (42CFR 457.1005(b))**

6.4.1.2. The cost of such coverage must not be greater, on an average per child basis, than the cost of coverage that would otherwise be provided for the coverage described above.; Describe the cost of such coverage on an average per child basis. (Section 2105(c)(2)(B)(ii)) (42CFR 457.1005(b))

6.4.1.3. The coverage must be provided through the use of a community-based health delivery system, such as through contracts with health centers receiving funds under section 330 of the Public Health Service Act or with hospitals such as those that receive disproportionate share payment adjustments under section 1886(c)(5)(F) or 1923 of the Social Security Act. Describe the community based delivery system. (Section 2105(c)(2)(B)(iii)) (42CFR 457.1005(a))

6.4.2. ☐ **Purchase of Family Coverage. Describe the plan to purchase family coverage. Payment may be made to a state for the purpose of family coverage under a group health plan or health insurance coverage that includes coverage of targeted low-income children, if**

it demonstrates the following: **(Section 2105(c)(3)) (42CFR 457.1010)**

6.4.2.1. **Purchase of family coverage is cost-effective relative to the amounts that the state would have paid to obtain comparable coverage only of the targeted low-income children involved; and (Describe the associated costs for purchasing the family coverage relative to the coverage for the low income children.)** **(Section 2105(c)(3)(A)) (42CFR 457.1010(a))**

6.4.2.2. **The state assures that the family coverage would not otherwise substitute for health insurance coverage that would be provided to such children but for the purchase of family coverage.** **(Section 2105(c)(3)(B)) (42CFR 457.1010(b))**

6.4.2.3. **The state assures that the coverage for the family otherwise meets title XXI requirements.** **(42CFR 457.1010(c))**

Section 7. Quality and Appropriateness of Care

☐ **Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan, and continue on to Section 8.**

7.1. Describe the methods (including external and internal monitoring) used to assure the quality and appropriateness of care, particularly with respect to well-baby care, well-child care, and immunizations provided under the plan. **(2102(a)(7)(A)) (42CFR 457.495(a))**

The state views the use of quality standards, performance measurement information strategies and quality improvement strategies as critical ingredients to transforming access to health plan coverage from the provision of access to the creation of a medical home. Below is a description of how California will use a number of tools and strategies in the Healthy Families Program and C-CHIP to ensure health care coverage translates to meaningful access to necessary services. AIM and Medi-Cal are not addressed separately. In the case of AIM, its operations substantially parallel the Healthy Families purchasing pool. Thus the description of that pool applies to AIM. Medi-Cal is addressed in California's Title XIX plan.

Will the state utilize any of the following tools to assure quality?
(Check all that apply and describe the activities for any categories utilized.)

7.1.1. ☑ **Quality standards**

Insurance Programs. MRMIB will monitor quality standards in the purchasing pool and voucher programs through:

- Analysis and trending of reports from health, dental and vision plans. MRMIB staff will collect and analyze a variety of reports generated by participating plans, regulatory entities, and external review organizations to monitor the quality of care received and to focus plan efforts on areas needing improvement. These reports include:

  - Benefit Grievances: Benefit grievances filed by Healthy Families subscribers with participating plans. Participating plans will be contractually required to report benefit grievances once a year. These reports will be shared with subscribers who request the information. In addition, MRMIB will track any publicly available information on the number and type of benefit grievances filed by all subscribers enrolled in a participating plan (Department of Corporations reports all benefit grievances filed with plans annually). Grievance information will be used by MRMIB to identify plan performance

needing improvement and to form the basis of future performance standards.

- Regulatory Entity Reports: MRMIB will work with the state's two health insurance industry regulatory entities (the Departments of Insurance and Corporations) to assure that all publicly available data on health plan performance is known to MRMIB.

- Enrollment and Disenrollment Reports: These reports will be generated by the program's administrative contractor and used by MRMIB as an early warning system of problems with a particular plan or medical group.

- Implementation of a risk assessment/risk adjustment process to minimize any financial incentives health plans may have to attempt to enroll healthier than average enrollees. While some observers view risk adjustment mechanisms in solely financial terms, MRMIB believes that inclusion of risk adjusted premium payments to plans is the single most important activity that MRMIB can undertake to assure the quality of care. MRMIB has been a pioneer in the risk adjustment field. In the HIPC, MRMIB currently oversees one of the nation's few operational risk adjustment processes. MRMIB believes that risk adjustment provides the necessary balance to the aggressive price negotiations undertaken in collective purchasing arrangements such as a purchasing pool. Through use of risk adjusted premiums, plans that provide quality services in an efficient manner would accrue the greatest financial benefit. MRMIB intends to seek philanthropic funding for development of a child focused risk assessment methodology.

  MRMIB intends to implement such a methodology in the third year of program operation. Implementation of risk assessment/adjustment in the third year of program operations will permit MRMIB to develop an understanding of the health risk based issues in children's health care and provide time to assure that all stakeholders are able to participate in development of the methodology.

- Monitoring the accreditation status of participating plans by entities such as the National Committee for Quality Assurance (NCQA). MRMIB intends to provide accreditation status information to parents to assist them in selecting a health, dental and vision plan.

MRMIB will identify the quality indicators to be used for the purchasing pool plans as follows:

- The specific indicators to be tracked will focus on child or adolescent specific outcome measures, such as the immunization status of two year olds. To the extent feasible, MRMIB intends to utilize the audited HEDIS measures generated by the California Cooperative HEDIS Reporting Initiative (CCHRI). CCHRI is a collaborative effort of purchasers, providers and plans who are committed to produce audited performance data on health plans which can be compared across plans and tracked over time. The health plans participating in CCHRI represent 95% of the commercially enrolled California health maintenance organization population. At present, the only audited child-specific HEDIS measure being collected by CCHRI is the immunization status of two year olds. Until audited measures are available, MRMIB will collect unaudited health plan reported information on other HEDIS child and adolescent based measures. MRMIB anticipates that the number of indicators collected during each contract period will expand as the field of outcome based quality measurement matures and as health plan's ability to produce data increases in response to purchasers demands.

- Each of the contacts between MRMIB and participating health, dental and vision plans will contain specific performance objectives. In developing these objectives, MRMIB will be guided by oral and written testimony received during the program development process, and by advice provided by the Healthy Families Advisory Panel. These standards may relate to clinical, access, or customer service based standards of quality. Those standards which are adopted by MRMIB will be included in contracts with participating health, dental and vision plans. The performance measures will be adopted by MRMIB in December of 1997 and will be included in each of the Model Contracts (health, dental and vision). The Model Contracts are the documents from which MRMIB will negotiate agreements with each of its plan partners. While MRMIB has not yet determined the specific performance measures for each of the contracts, the purchasing power of the Healthy Families Program subscriber base will provide MRMIB with significant ability to influence plan behavior.

CHDP. The Healthy Families gateway program, CHDP, reimburses for periodic health assessments and immunizations for children and adolescents under 21 years of age eligible for Medi-Cal and for those 19 years of age and under whose family's income is 200 percent of the federal poverty level or below. Through its administration of the CHDP and CCS programs, the Department of Health Services will use a variety of approaches to monitor

quality standards. The state CHDP program is responsible for developing standards for the care delivered in a complete health assessment, including those components required by the EPSDT program (dental, nutrition, vision and hearing screening). In general, the standards of the American Academy of Pediatrics serve as the basis for preventive services standards. The program distributes Health Assessment Guidelines to enrolled CHDP providers (physicians, medical clinics, medical groups, and certified pediatric or family nurse practitioners) to provide a framework for the quality of care to be delivered during an assessment, including appropriate screening methodologies and specific tools. The local CHDP program is responsible for enrolling providers, both those who wish to provide health assessments and those who wish to deliver complete health care, if they meet the criteria outlined in Section 6860 of Title XXI. It also identifies providers who may be providing substandard services and can require corrective action in order to continue program participation.

Specialized Services. The CCS program develops standards for provider participation under the authority of Section 123925 of the Health and Safety Code. Providers, from individual pediatric specialists and sub-specialists to hospital inpatient facilities, wishing to participate in the program apply to have their qualifications reviewed and assessed. CCS state program staff perform on-site review of hospital facilities and special care centers that includes the determination of the appropriateness of the professional staff delivering care to CCS-eligible children and the quality of the health care provided (generally through the review of medical records).

The CCS program staff authorizes paneled and approved providers to deliver services to eligible children. CCS case management, through its prior authorization requirements, can insure that children with serious physically handicapping conditions are receiving health care services from the appropriate type and level of provider.

The requirements for provider selection, quality improvements systems and documentation that are used for a similar population in the Medi-Cal program will be required of county Mental Health Plans under this program. In addition, California has been a national leader in the implementation of a performance outcome system for children with serious emotional disturbance. Children with serious emotional disturbance receiving Mental Health Plan services under Title XXI will be included in this effort. Families will be able to work with the Mental Health Plans on a formal or informal basis to resolve problems.

COUNTY CHILDREN'S HEALTH INSURANCE PROGRAM

MRMIB will monitor quality standards in the C-CHIP projects through:

- Analysis and trending of reports from health, dental and vision plans. MRMIB staff will collect and analyze a variety of reports generated by participating plans, regulatory entities, and external review organizations to monitor the quality of care received and to focus plan efforts on areas needing improvement. These reports include:

  - Benefit Grievances: Benefit grievances filed by Healthy Families subscribers with participating plans. Participating plans will be contractually required to report benefit grievances once a year. These reports will be shared with subscribers who request the information. In addition, MRMIB will track any publicly available information on the number and type of benefit grievances filed by all subscribers enrolled in a participating plan (Department of Corporations reports all benefit grievances filed with plans annually). Grievance information will be used by MRMIB to identify plan performance needing improvement and to form the basis of future performance standards.

  - Regulatory Entity Reports: MRMIB will work with the state's two health insurance industry regulatory entities (the Departments of Insurance and Corporations) to assure that all publicly available data on health plan performance is known to MRMIB.

- Monitoring the accreditation status of participating plans by entities such as the National Committee for Quality Assurance (NCQA).

- The specific indicators to be tracked will focus on child or adolescent specific outcome measures, such as the immunization status of two year olds. To the extent feasible, MRMIB intends to utilize the audited HEDIS measures generated by the California Cooperative HEDIS Reporting Initiative (CCHRI). CCHRI is a collaborative effort of purchasers, providers and plans who are committed to produce audited performance data on health plans which can be compared across plans and tracked over time. The health plans participating in CCHRI represent 95% of the commercially enrolled California health maintenance organization population. At present, the only audited child-specific HEDIS measure being collected by CCHRI is the immunization status of two year olds. Until audited measures are

available, MRMIB will collect unaudited health plan reported information on other HEDIS child and adolescent based measures. MRMIB anticipates that the number of indicators collected during each contract period will expand as the field of outcome based quality measurement matures and as health plan's ability to produce data increases in response to purchasers demands.

7.1.2. ☑ Performance measurement

MRMIB will measure performance of purchasing pool plans through three strategies:

- Collaboration on performance measures with other large purchasers such as CalPERS and the Pacific Business Group on Health (PBGH). MRMIB is a member organization of PBGH. Using the purchasing power of the Healthy Families subscriber base, MRMIB intends to collaborate actively with other large purchasers to encourage the health plan and provider communities to move more quickly to identify and expanded set of clinical quality indicators.

- Requiring all participating health plans to submit yearly results of the latest version of the Health Employer Data Information Set (HEDIS). As mentioned above, audited HEDIS results will be used when available.

- Establishing contractual agreements with participating plans obligating them to submit the results of standardized subscriber satisfaction surveys. While the exact survey instrument has not been determined, the instrument used by the NCQA will be evaluated for its applicability to the issues of importance to children and adolescents.

MRMIB will evaluate and select a means to enforce plan performance related to the performance standards. Enforcement can take one of several approaches. These include using either a fiscal (or enrollment) penalty based system in which plans are penalized when MRMIB identifies a deficiency, or a performance target based system in which plans agree to put a percentage of their premium at risk if they do not achieve the predetermined performance levels.

COUNTY CHILDREN'S HEALTH INSURANCE PROGRAM

As noted above, MRMIB currently has a mechanism in place to measure performance of the county LIs and COHS within the construct of the Healthy

Families Program contracts. As such, MRMIB will assess which of the measures will best meet the objectives of measuring performance of the LIs and COHS given that the length of time C-CHIP projects will be funded is presently unknown.

7.1.3. ☑ Information strategies

MRMIB will use the following information strategies to improve and assure the quality of service provided through the Healthy Families Purchasing Pool Program:

- The Healthy Families Program brochure/application will include an easy to read chart summarizing the program benefits. Participating plans will be required to distribute to all subscribers a detailed description of covered benefits and exclusions in their Evidence of Coverage Document (EOC), a list of physicians and hospitals available in their network (Directories) and an identification card for subscribers to use to access services. Through its contractual relationships with plans, MRMIB will require the provision of these documents to families no later than the effective date of coverage. In addition, all plans participating in the Healthy Families program will be required to make EOCs available on a pre-enrollment basis to those families wishing to review the coverage documents in detail prior to selecting a health plan.

- The Healthy Families Program brochure/application will include a section where all participating plans will have the opportunity to respond to a standardized set of topics of interest to families when selecting a plan, such as a description of the plan's provider network, how language support services are accessed, the plan's view of why a family should want to select the plan, and how approval for specialty care is handled in the plan. The exact list of issues will be developed by MRMIB using input received at MRMIB public meetings, available market research, and in consultation with the Healthy Families Advisory Panel.

- The Healthy Families Program brochure/application will include a chart comparing responses to commonly asked questions. These questions will be generated using input received at the MRMIB public meetings, available market research, and in consultation with the Healthy Families Advisory Panel. These may include answers to questions such as:

- How many times can a child change their primary care physician in one benefit year?
- Does the plan require physicians to prescribe pharmacy products from a list of drugs (a formulary) approved by the plan?
- What is the total number of primary care physicians in the plan?

- MRMIB's experience in purchasing health benefits for small employers and their employees' families through HIPC shows that most families want to know the plans that include the child's physician when selecting a plan. To respond to this consumer need the Healthy Families Program will create a Provider Information Service. The Provider Information Service will be modeled on the Physician Super Directory developed by MRMIB for its small employer purchasing pool. It will include a listing of the pediatricians, family practice and general practice doctors, clinics/medical groups and hospitals that will be available through Healthy Families participating health plans. Additional information will include languages spoken in the physician's office, the gender of the physician, and if the physician is accepting new patients. The Provider Information Service will be available to families as they make their initial health plan choices and again at each annual open enrollment.

- MRMIB will require all plans providing services to Healthy Families program subscribers to prominently display in their Evidence of Coverage documents the grievance procedures of the plan and the plan's regulatory entity's toll free phone number.

- Application/enrollment materials will be available in English, Spanish, and other threshold languages designated by the Department of Health Services. Staff answering the toll-free number used by the administrator of the program will speak English and Spanish and have access to translator services for other languages.

COUNTY CHILDREN'S HEALTH INSURANCE PROGRAM

The county LI and COHS will provide to its enrolled members a detailed description of covered benefits, exclusions, and grievance procedures in their Evidence of Coverage (EOC) booklet.

7.1.4. ☑ **Quality improvement strategies**

All of the approaches described under quality standards, performance

measurement, and information strategies will be used by MRMIB to encourage quality improvement by participating plans. This will be done through five strategic approaches. These are:

- Keeping up to date on developments in quality improvement, including any indicators that may be developed regarding the high quality medical home;
- Feeding back information to plans to help them understand their own performance over time and how they compare to other plans providing services to Healthy Families Program subscribers;
- Enforcing of contractual provisions which link quality based measures to plan performance;
- Increasing plan performance targets over time; and
- Providing quality based information to families. This final approach empowers the consumer to punish or reward plans with enrollment based on the value each family places on the quality standards.

COUNTY CHILDREN'S HEALTH INSURANCE PROGRAM

As noted in MRMIB's response in section 7.1.2., the authorizing statute which established the C-CHIP projects provides funding availability only for the current federal fiscal year ending September 30, 2003. MRMIB will determine which of the quality improvement strategies stated above will best our common goal of monitoring and improving the quality of service and benefits provided by the LI and COHS.

7.2. Describe the methods used, including monitoring, to assure: **(2102(a)(7)(B)) (42CFR 457.495)**

7.2.1. Access to well-baby care, well-child care, well-adolescent care and childhood and adolescent immunizations. **(Section 2102(a)(7)) (42CFR 457.495(a))**

7.2.2. Access to covered services, including emergency services as defined in 42 CFR 457.10. **(Section 2102(a)(7)) 42CFR 457.495(b))**

7.2.3. Appropriate and timely procedures to monitor and treat enrollees with chronic, complex, or serious medical conditions, including access to an adequate number of visits to specialists experienced in treating the specific medical condition and access to out-of-network providers when the

network is not adequate for the enrollee's medical condition. **(Section 2102(a)(7)) (42CFR 457.495(c))**

7.2.4. Decisions related to the prior authorization of health services are completed in accordance with state law or, in accordance with the medical needs of the patient, within 14 days after the receipt of a request for services. **(Section 2102(a)(7)) (42CFR 457.495(d))**

Section 8. Cost Sharing and Payment (Section 2103(e))

☐ **Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan, and continue on to Section 9.**

8.1. Is cost-sharing imposed on any of the children covered under the plan? (42CFR 457.505)

8.1.1. ☑ **YES**
8.1.2. ☐ **NO, skip to question 8.8.**

8.2. Describe the amount of cost-sharing, any sliding scale based on income, the group or groups of enrollees that may be subject to the charge and the service for which the charge is imposed or time period for the charge, as appropriate.
(Section 2103(e)(1)(A)) (42CFR 457.505(a), 457.510(b) &(c), 457.515(a)&(c))

8.2.1. Premiums:

Purchasing Pool Premiums

*Family Value Package***.** MRMIB will designate one or more "Family Value Packages" (FVP's) in each geographic area. The FVP is the combination of health, dental, and vision plans which offer the best prices to the program. MRMIB has the ability to designate a range of prices as the "lowest" cost value to the state. The exact range will be designated by MRMIB in the program regulation process.

The Family Value Packages will have the following monthly premiums - or "family contribution amounts":

	Family Value Package
Above 100-150% FPL	
One child	$ 7
Two or more children	14
Above 150-200% FPL	
One child	9
Two children	18
Three or more children	27

Families who prepay three months of premiums will not have to pay a premium for the fourth month.

Community Provider Plan. MRMIB will also designate a "Community

Provider Plan" by geographic area. This is the plan in the area with the highest percentage of traditional and safety net providers. These packages will have the following monthly base premiums:

	Community Provider Plan
Above 100-150% FPL	
One child	$ 4
Two or more children	8
Above 150-200% FPL	
One child	6
Two children	12
Three or more children	18

Again, families that pay 3 months of premiums in advance will receive the fourth month free.

The structure of Healthy Families has been designed to assure that subscribers have access to a wide variety of plans in the Family Value Package which have copayments and premium payments that are within the Title XXI limits, but also to allow the subscribers to choose, and pay the cost differential for, other higher cost plans.

In recognition that many low income families will want to choose a lower priced plan and to ensure that there is wide access to the FVP's, MRMIB recently made two changes in the definition of the FVP plan that will significantly increase the number of plans that will qualify as FVP's. We discuss these changes in detail in response to your questions.

MRMIB's regulations guarantee that a FVP will be available to all enrollees. However, in recognition that many low income families will want to choose a lower priced plan and to ensure that there is wide access to the FVP plans, MRMIB recently made a change in the definition of the FVP plan that will significantly increase the number of plans that will qualify. Specifically, MRMIB increased the percentage of cost variance that forms the boundaries of the FVP from 5 to 10 percent, and included the average of two lowest priced combinations of health, dental and vision plans as the bottom-end pricing point.

This means that if the average price to the state for the two lowest cost combinations of health, dental and vision plans is $60 – up to $66 – would be available to subscribers for no additional premium. Designation of FVP's will be done on a county by county basis, thus assuring that regional pricing

differences do not undermine the approach. Thus, subscribers will have a significant choice of plans with costs to the beneficiary under the federal limits. This also assures that there is adequate capacity among the FVP plans so that every subscriber will have access to the lowest priced plan. If MRMIB determines that the 10 percent range does not allow sufficient capacity in an area, it is authorized to extend the FVP range further.

One of the most important principles of purchasing pools generally, and the Healthy Families model in particular, is allowing people to have a bountiful selection of plans (and, therefore, providers) from which to choose and a fiscal incentive to encourage health plans to seek to be one of the lower cost plans. The incentive that subscribers have to choose the lower cost plan is a prerequisite of the ability of a purchasing pool to contain overall costs of the program. This is because health pans will compete to be among the lower price plans so that they will be chosen. These principles underlie the creation of the Family Value Package concept in Healthy Families as well as the structure of the state employees purchasing pool run by Public Employees Retirement System (PERS) and the small employers purchasing pool (HIPC) run by MRMIB.

Family Contribution Sponsors

The first 12 months of an applicant's premium may be paid by a Family Contribution Sponsor. A Family Contribution Sponsor must register with MRMIB by completing and returning a Family Contribution Sponsorship Registration Form and receiving a sponsor identification number. The following persons or entities are not eligible to be a Family Contribution Sponsor:

1. a person that is a health care, dental care or vision care provider that participates in the Healthy Families Program or an organization composed primarily of or controlled by such persons,
2. an entity, including governmental, school, non-profit and charitable organizations, that is, or that operates, an institution or facility that is a health care, dental care or vision care provider that participates in the Healthy Families Program,
3. a participating plan,
4. any person or entity acting on behalf of or representing a person or entity identified in (1) through (3) above.

Family Contribution Sponsors must certify that they are not ineligible under 1 of the 4 categories listed above. For each applicant being sponsored, the Family Contribution Sponsor shall submit payment for 12 months of family

premiums and the completed and signed Family Contribution Sponsorship Form with the Healthy Families Application. No premium adjustments for a sponsored family will be made during the first 12 months in the program. MRMIB may disqualify a sponsor if it determines that the sponsor has violated or encourage an applicant to violate program rules.

AIM

Subscribers pay premiums equal to 2% of the families annual income for coverage of the pregnant woman and the infant through age one. ~~An additional $100 is charged for the second year of the infant's life.~~ [Note: The state seeks FFP ~~only~~ for infants up to age ~~one~~ two with family income between 200-~~250%~~300% FPL.]

COUNTY CHILDREN'S HEALTH INSURANCE PROGRAM

Premiums range from $4 - $10 per month and three of the four C-CHIP projects charge premiums on a quarterly basis; the fourth C-CHIP project charges monthly. As is true in the Healthy Families Program, discounts are given when payments are made in advance: if three quarters are paid in advance, the fourth quarter is free; if three months are paid in advance, the fourth month is free. Only one county has established a monthly premium maximum cap of $18.

8.2.2. Deductibles: None

8.2.3. Coinsurance or copayments:

No coinsurance. Copayments as described below.

Health Coverage

MRMIB will establish copayment levels in amounts that reflect the copayment levels for the state's selected benchmark plan, the Public Employee's Retirement System. However, no copayments will be charged for prenatal, well baby, well child or immunization services or benefits. Further, the amount of copayments a family will pay in a given year is limited to $250, as opposed to the $1,500 annual copayment maximum in the benchmark plan. Copayment amounts are detailed by benefit in the description of benefits in section 6.2 of this application. The copayment for most services (office visits, prescriptions) is $5.00.

We are aware that the Secretary of the Department of Health and Human

Services is presently reviewing policy options related to her authority to adjust Medicaid copayment amounts for inflation or any other reason the Secretary determines is reasonable. We note that if the Secretary did adjust the 1978 copayments for inflation, the copayments would equal $7 for families with incomes below 150 percent of FPL – well above the $5 the Healthy Families plan requires for non-preventive services.

We urge the Secretary to adjust the copayments for inflation. By exercising her authority, the Secretary will enable Healthy Families to charge a copay that is consistent with cost-sharing requirements of similarly situated families insured through employer-based or privately purchased coverage. A key element in mitigating the incentive for families to drop employer based coverage in favor of Healthy Families coverage is assuring that Healthy Families coverage mirrors to the greatest degree possible employer-based coverage available in the general marketplace. Five dollar copays are the absolute lowest copays used in the California insurance market. Adopting a lower copay for Healthy Families could have the effect of exacerbating crowd out of private insurance coverage. Further, because Healthy Families utilized health plans' commercial offerings, their operating systems are set up for $5 copays rather than $3 copays.

Dental and Vision Coverage

In the regulations which the Board adopted at its January 29, 1998 meeting, the Board approved copayments for both dental and vision care at $5 for non-preventive services.

COUNTY CHILDREN'S HEALTH INSURANCE PROGRAM

Copayments under the C-CHIP projects range from $5 - $10 for non-emergency room visits. Two of the four counties charge $15 copays for emergency room visits, and all charge $5 copays for prescriptions.

8.2.4. Other: N/A

8.3. Describe how the public will be notified, including the public schedule, of this cost-sharing (including the cumulative maximum) and changes to these amounts and any differences based on income. **(Section 2103(e)((1)(B)) (42CFR 457.505(b))**

The notification process is disclosed in HFP regulations, evidence of coverage, and the HFP Handbook, and its contracts. The HFP is currently in the process of reviewing its subscriber notification procedures. We anticipate that our review will be completed with necessary changes implemented by January, 2003. These changes

will not be implemented until January, 2003 because contractual changes are necessary to implement them. We will provide more detail on our process for CMS when the contracts are finalized.

COUNTY CHILDREN'S HEALTH INSURANCE PROGRAM

Families applying for C-CHIP will be informed about the cost sharing requirements from the same individuals conducting outreach; the local state trained application assistants, county social service staff, and the health plan staff. In addition, cost sharing information is included in the members Evidence of Coverage booklet which is mailed to each family when a child within the household is enrolled.

8.4. The state assures that it has made the following findings with respect to the cost sharing in its plan: (Section 2103(e))

8.4.1. ☑ Cost-sharing does not favor children from higher income families over lower income families. (Section 2103(e)(1)(B)) (42CFR 457.530)

8.4.2. ☑ No cost-sharing applies to well-baby and well-child care, including age-appropriate immunizations. (Section 2103(e)(2)) (42CFR 457.520)

8.4.3 ☑ No additional cost-sharing applies to the costs of emergency medical services delivered outside the network. (Section 2103(e)(1)(A)) (42CFR 457.515(f))

8.5. Describe how the state will ensure that the annual aggregate cost-sharing for a family does not exceed 5 percent of such family's income for the length of the child's eligibility period in the State. Include a description of the procedures that do not primarily rely on a refund given by the state for overpayment by an enrollee: (Section 2103(e)(3)(B)) (42CFR 457.560(b) and 457.505(e))

Healthy Families Insurance Program

Families with incomes over 150% of poverty:

California ensures that the annual aggregate cost-sharing for a family does not exceed 5% of a family's income as is required by Section 2103(3)(B) of Title XXI. Healthy Families' premiums are established in statute, along with a limit of $250 on the total copayments which would be required of a family annually. Table 1 below demonstrates that:

- The maximum cost sharing for a family at 150% of poverty (Column V) falls well within the 5% annual cap (Column III).
- The number of visits that a child or children would have to make to a dentist or

vision provider to exceed the 5% ceiling. Note that vision is one visit per year so the number of visits would actually be primarily visits to the dentist.

- We have chosen the lowest possible family income for the chart (150% FPL) therefore; families at higher incomes would have to incur even greater number of visits to exceed the limit.
- We think that column V demonstrates that families would not pay above the 5 percent ceiling level.

Table 1: Aggregate Cost Sharing for Families Above 150%

I	II	III	IV	V	VI
Family Size	Annual Income of a Single Parent Family @ 150% FPL	5% Ceiling	Annual Premium Contribution*	Annual Premium + $250 Family Cap on Health Copays	Number of Dental and Vision Visits for Non-Preventive Services Needed to Exceed Ceiling
1 child	$ 15,915	$ 795.75	$ 108	$ 358	87
2 children	$ 19,995	$ 999.75	$ 216	$ 466	106
3+children	$ 24,075	$1,203.75	$ 324	$ 574	125

***** Does not include premium discount for prepayment. If included, would reduced figures in this column by 25%.

Families with incomes under 150% of poverty:

Premiums. California will ensure that the annual aggregate cost-sharing for a family with incomes less than 150% FPL is less than that required by Section 1916(b)(1) and Section 1916(2)(3) as is required under Title XXI. The maximum monthly premium charge for Healthy Families insurance programs is consistent with the standards established under Section 447.52 of Title 42 CFR. As noted earlier, Healthy Families' premiums for families below 150% FPL are $7 per child per month (with a maximum family contribution of $14 per family per month). Table 2 below demonstrates that the maximum premium payments for a family at 100% FPL under Healthy Families (Column II) falls within the maximum monthly charges established under Section 447.42 of Title 42 of the CFR. Note that the maximum monthly charges identified

below were established in 1978 and are unadjusted for inflation.

Table 2: Premium Contributions for Families below 150% FPL

I. Family Size	II. Income of a Single Parent Family at 100% FPL	III. Premium Contribution*	IV. Medicaid Maximum Monthly Charge (Unadjusted for Inflation)
1 child	$884 mo./ $10,610 yr.	$7 mo./ $84 yr.	$16 mo./ $192 yr.
2 children	$1,111 mo./ $13,330 yr.	$14 mo./ $168 yr.	$15-$16 mo./ $180-$192 yr.

* Does not include premium discount for families who prepay 3 months in advance.

Copays. Healthy Families sets health benefit copayments at $5, the lowest priced copayments available on the private market in California today. A copayment level of $5 is reasonable for families with incomes below 150% FPL for a number of reasons. First, Healthy Families will charge no copays for any preventive services, and no family will be required to pay any copayments after it has contributed $250 annually. Also, Healthy Families will not charge any copay for institutional services, in contrast to Medicaid law which allows a 50% copayment for the first day of institutional care. Finally, Title XXI requires that cost sharing not exceed an amount that is "nominal" under Medicaid law, with appropriate adjustment for inflation or other reasons as the Secretary determines to be reasonable. The maximum copayments for a service costing over $50 is $3 under Medicaid law and was established in 1978. When adjusted for 1996 using the California Consumer Price Index (CPI), that copayment level rises to over $7, well above the $5 copay proposed by California.

The $250 limit does not apply to dental or vision coverage. This is because the provision of dental coverage under Title XXI is not required of states who opt to participate in the CHIP program. California, recognizing the value of these services and the importance of the dental health of our targeted low-income children, adopted the State employees' benefit package and copayments for dental and vision coverage. As these are optional benefits, and as the authorizing statute applies the $250 cap only to health benefits, our view is that the cap need apply only to health coverage.

Further, as California does not have copays for most dental services that children receive (preventive exams, cleanings, restorations, sealants, and fluoride treatments) it has lowered all other copays to five dollars. Children who meet CCS conditions will receive their services (orthodontics) from CCS without a copay. Therefore, including dental services in the $250 maximum is not needed. Very few families will have to pay a copay at all for dental services and those that do will be for a specific condition

(root canal) which should have limited utilization. As shown by HCFA's questions, inclusion of dental in the maximum would be very complicated and the administrative cost and confusion to families could far outweigh any practical value of this inclusion.

COUNTY CHILDREN'S HEALTH INSURANC PROGRAM

California's approved State Plan demonstrates that the cost sharing requirements do not exceed those allowable under Title XXI. Even though the cost sharing requirements are slightly higher in the C-CHIP projects compared to the Healthy Families Program, the higher income level is commensurate with the difference. Therefore we believe the cost sharing requirements continue to be within the allowable limits established under Title XXI.

AIM

The amount of premium charged for AIM coverage is limited to 2% of family income. No copays are charged for AIM services.

8.6 Describe the procedures the state will use to ensure American Indian (as defined by the Indian Health Care Improvement Act of 1976) and Alaska Native children will be excluded from cost-sharing. **(Section 2103(b)(3)(D)) (42CFR 457.535)**

8.7 Please provide a description of the consequences for an enrollee or applicant who does not pay a charge. **(42CFR 457.570 and 457.505(c))**

Currently, if a program participant fails to make a payment, the next month's invoice he receives includes a 30 day past due warning. The second month's invoice includes the amount due for the previous month and the current month, the date by which payment must be remitted, and the date the coverage will end if payment is not made. All invoices with past due warnings include a statement that if the subscriber is disenrolled for non-payment, he or she must wait 6 months before he or she can enroll in HFP again.

If the premium is 45 days past due, a warning letter is sent to the applicant, which includes information on payment options and the disenrollment date. If the premium has not been received on the 20th of the second month, a courtesy call is placed to the applicant. The applicant is reminded that a premium payment is due and that his or her child will be disenrolled as of the end of the month. He or she is also questioned regarding whether he or she received the notification. A last billing statement is also mailed to the applicant on the 20th day of the month, and if HFP has not received payment by the last day of the second month, a disenrollment with appeal information letter is sent to the applicant.

HFP is in the process of reviewing its disenrollment practices. It is anticipated that revised practices will be implemented in January, 2003. These changes will not be implemented until January, 2003 because contractual changes will be necessary to implement them. We will provide more detail on our process for CMS when the contracts are finalized.

COUNTY CHILDREN'S HEALTH INSURANCE PROGRAM

In the development of the C-CHIP projects, the counties implemented the core design of the Healthy Families Program with some variation. As such, the notification process described above for the Healthy Families Program is the minimum which occurs in the C-CHIP projects. Some C-CHIP projects send four notices prior to disenrollment and others include phone calls to the applicant prior to disenrollement. In addition, all four C-CHIP projects have established enrollee protections as required under Title XXI. These enrollee protections include continued enrollment in the program during the time an appeal disputing the decision to disenroll from the program is being reviewed.

8.7.1 Please provide an assurance that the following disenrollment protections are being applied:

- ☑ **State has established a process that gives enrollees reasonable notice of and an opportunity to pay past due premiums, copayments, coinsurance, deductibles or similar fees prior to disenrollment. (42CFR 457.570(a))**
- ☐ **The disenrollment process affords the enrollee an opportunity to show that the enrollee's family income has declined prior to disenrollment for non payment of cost-sharing charges. (42CFR 457.570(b))**
- ☐ **In the instance mentioned above, that the state will facilitate enrolling the child in Medicaid or adjust the child's cost-sharing category as appropriate. (42CFR 457.570(b))**
- ☑ **The state provides the enrollee with an opportunity for an impartial review to address disenrollment from the program. (42CFR 457.570(c))**

8.8 The state assures that it has made the following findings with respect to the payment aspects of its plan: (Section 2103(e))

8.8.1. ☑ **No Federal funds will be used toward state matching requirements. (Section 2105(c)(4)) (42CFR 457.220)**

8.8.2. ☑ **No cost-sharing (including premiums, deductibles, copays, coinsurance and all other types) will be used toward state matching requirements. (Section 2105(c)(5) (42CFR 457.224) (*Previously 8.4.5)***

8.8.3. ☑ **No funds under this title will be used for coverage if a private**

insurer would have been obligated to provide such assistance except for a provision limiting this obligation because the child is eligible under the this title.
(Section 2105(c)(6)(A)) (42CFR 457.626(a)(1))

8.8.4. ☑ **Income and resource standards and methodologies for determining Medicaid eligibility are not more restrictive than those applied as of June 1, 1997.** **(Section 2105(d)(1)) (42CFR 457.622(b)(5))**

8.8.5. ☑ **No funds provided under this title or coverage funded by this title will include coverage of abortion except if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest.** **(Section 2105)(c)(7)(B)) (42CFR 457.475)**

8.8.6. ☑ **No funds provided under this title will be used to pay for any abortion or to assist in the purchase, in whole or in part, for coverage that includes abortion (except as described above).** **(Section 2105)(c)(7)(A)) (42CFR 457.475)**

Section 9. Strategic Objectives and Performance Goals and Plan Administration (Section 2107)

9.1. Describe strategic objectives for increasing the extent of creditable health coverage among targeted low-income children and other low-income children: (Section 2107(a)(2)) (42CFR 457.710(b))

California has developed strategic objectives for increasing the extent of creditable health coverage for targeted low-income children and other low-income children. These objectives are all focused toward the state's overarching concern: that the outcome of increasing the extent of creditable health coverage will significantly improve the health status of California's children. The strategic objectives are to:

1. Increase the awareness of low income uninsured families about the availability of comprehensive low or no cost health coverage for children as well as the importance of timely and ongoing care for children. Motivate such families to obtain coverage for their children.

2. Provide a choice of health plans for families to choose from in obtaining coverage for their children.

3. Provide an application and enrollment process which is easy for targeted low-income families to understand and use.

4. Assure that financial barriers do not keep families from enrolling their children in the program.

5. Assure that health services purchased by the program are accessible to enrolled children.

6. Assure the participation of community-based organizations in outreach and education activities.

7. Encourage the inclusion of traditional and safety net providers in health plan networks.

8. Strengthen and encourage employer-sponsored coverage to the maximum extent possible.

9. Assure that enrolled children with significant health needs receive access to appropriate care.

9.2. Specify one or more performance goals for each strategic objective identified: (Section 2107(a)(3)) (42CFR 457.710(c))

The following performance goals and measures have been identified for each of the strategic objectives defined above:

Objective 1: Increase the awareness of low income families about the availability of comprehensive low or no cost health coverage for children as well as the importance of timely and ongoing care for children. Motivate such families to obtain coverage for their children.

Performance goals:

1.1 Increase the percentage of Medi-Cal eligible children who are enrolled in the Medi-Cal program.

1.2 Reduce the percentage of uninsured children in target income families that have family incomes above no cost Medi-Cal levels.

1.3 Reduce the percentage of children using the emergency room as their usual source of primary care.

Proposed measures:

California will use Current Population Survey longitudinal data as well as Medi-Cal and emergency room data as obtained by the Department of Health Services.

Objective 2: Provide a choice of health plans for families to choose from in obtaining coverage for their children.

Performance goals:

2.1 The Healthy Families insurance pool and Medi-Cal will provide each family with two or more health plan choices for their children.

Proposed measures:

California will use a quantitative evaluation of the number of health plan choices provided to Medi-Cal and Healthy Families enrollees. California will conduct an analysis by region of the demographic distribution of members by health plan in Medi- Cal and Healthy Families.

Objective 3: Provide an application and enrollment process which is easy for targeted low-income families to understand and use.

Performance goals:

3.1 Assure that Medi-Cal and the insurance program's enrollment contractor provide written and telephone services in the languages spoken by the target population.

3.2 Develop an application process that can be completed without an in-person meeting.

Proposed measures:
MRMIB will assess its effectiveness in meeting these goals for the insurance program. MRMIB's enrollment contractor will track the percentage of insurance program applications which are approved without being mailed back for additional information, and will ensure that the average time interval between receipt of application and establishment of eligibility is no more than 10 days. By July 1, 1998, MRMIB will ensure that all enrollment materials for the insurance program are available in the threshold languages identified by DHS and that materials are available at an eighth grade reading level.

By June 1, 1998, DHS will develop a work plan for creating a simplified Medi-Cal application. By April 1, 1998, DHS will have all program enrollment materials in the threshold languages.

Objective 4: Assure that financial barriers do not keep families from enrolling their children in the program.

Performance goals:
4.1 Limit program costs to a point where cost of participating in health coverage will not exceed two percent of a family's annual household income.

Proposed measures:
California will survey uninsured persons in the target population to determine if financial barriers prevent their enrollment, and track such data longitudinally. MRMIB will also survey families disenrolling from the insurance program to assess whether cost influenced their decision to disenroll.

Objective 5: Assure that health services purchased by the program are accessible to enrolled children.

Performance goals:
5.1 Achieve year to year improvements in the percentage of targeted low income children that have had a visit with a primary care provider during the year.

5.2 Achieve year to year improvements in the percentage of targeted low income children that have had well-child examinations at the appropriate intervals for their age.

5.3 Achieve year to year improvements in the percentage of targeted low income children who receive required immunizations by age 2 and by age 13.

Proposed measures:
California will use HEDIS measures relevant to children's service accessibility for all health plans participating in the insurance program, and participating health plans will be contractually obligated to participate in annual audited HEDIS reporting.

Objective 6: Assure the participation of community-based organizations in outreach and education activities.

Performance goals:
6.1 Insure that a variety of entities experienced in working with targeted low income populations are eligible to receive the application assistance fee for assisting families with enrollment.

6.2 Insure that a variety of entities experience in working with targeted low income populations receive subcontracts with the outreach/education contractor have input in the development of culturally and linguistically appropriate outreach and enrollment materials.

Proposed measures:
DHS will require the outreach/education contractor to allocate a percentage of resources to fund the participation of community-based organizations in the state's outreach efforts, and will require the contractor to document their participation.

MRMIB will use its Advisory Board -- which includes representation from the community -- to receive external feedback on the participation of community based organizations in its use of the application assistance fee.

Objective 7: Encourage the inclusion of traditional and safety net providers in health plan networks.

Performance goals:
7.1 Achieve increases in the number of children enrolled in the insurance pool who have access to a provider located within their zip code.

7.2 Achieve increases in the number of children who have access to traditional and safety net providers as defined by MRMIB.

Proposed measures:
MRMIB will require participating plans to report annually on the number of subscribers selecting traditional and safety net providers.

Objective 8: Strengthen and encourage employer-sponsored coverage to the

maximum extent possible.

Performance goals:

8.1 Maintain the proportion of children under 200 percent of FPL who are covered under an employer-based plan, taking into account decreases in coverage due to increasing health care costs or a downturn in the economy.

Proposed measures:

California will use data from the Current Population Survey to assess changes in the insurance status of targeted low income children. In addition, when determining eligibility for the insurance program, MRMIB will ask questions relating to past employer-based insurance coverage, allowing California to track the number of children who have access to employment-based coverage and to ensure that children enrolling in Healthy Families are uninsured rather than dropping employment based coverage to participate in the program.

Objective 9: Assure that enrolled children with significant health needs receive access to appropriate care.

Performance goals:

9.1 Achieve year to year maintenance and/or improvements in the percentage of children with special health care needs with a source of insurance for primary care and specialty care.

9.2 Ensure that children with special health care needs experience no break in coverage/services as they access specialized services.

Proposed measures:

MRMIB will track the number of children with special health care needs who participate in the program. MRMIB will also monitor subscriber complaints and health plans' compliance with referral requirements.

9.3. Describe how performance under the plan will be measured through objective, independently verifiable means and compared against performance goals in order to determine the state's performance, taking into account suggested performance indicators as specified below or other indicators the state develops:
(Section 2107(a)(4)(A),(B)) (42CFR 457.710(d))

Measures are outlined in Section 9.2 above.

Check the applicable suggested performance measurements listed below that the state plans to use: (Section 2107(a)(4))

- **9.3.1.** ☑ **The increase in the percentage of Medicaid-eligible children enrolled in Medicaid.**
- **9.3.2.** ☑ **The reduction in the percentage of uninsured children.**
- **9.3.3.** ☐ **The increase in the percentage of children with a usual source of care.**
- **9.3.4.** ☐ **The extent to which outcome measures show progress on one or more of the health problems identified by the state.**
- **9.3.5.** ☑ **HEDIS Measurement Set relevant to children and adolescents younger than 19.**
- **9.3.6.** ☐ **Other child appropriate measurement set. List or describe the set used.**
- **9.3.7.** ☐ **If not utilizing the entire HEDIS Measurement Set, specify which measures will be collected, such as:**
  - **9.3.7.1.** ☐ **Immunizations**
  - **9.3.7.2.** ☐ **Well child care**
  - **9.3.7.3.** ☐ **Adolescent well visits**
  - **9.3.7.4.** ☐ **Satisfaction with care**
  - **9.3.7.5.** ☐ **Mental health**
  - **9.3.7.6.** ☐ **Dental care**
  - **9.3.7.7.** ☐ **Other, please list:**
- **9.3.8.** ☑ **Performance measures for special targeted populations.**

9.4. ☑ The state assures it will collect all data, maintain records and furnish reports to the Secretary at the times and in the standardized format that the Secretary requires. **(Section 2107(b)(1)) (42CFR 457.720)**

9.5. ☑ The state assures it will comply with the annual assessment and evaluation required under Section 10. Briefly describe the state's plan for these annual assessments and reports. **(Section 2107(b)(2)) (42CFR 457.750)**

The state will perform the annual assessments and evaluations required in Section 2108(a) to assess its progress in meeting the performance goals and measures identified in Section 9. Data necessary to prepare these reports will be drawn from administrative files maintained by the Healthy Families and Medi-Cal programs, the Current Population Survey, disenrollment surveys of Healthy Families Program participants, and HEDIS reports. In addition, the state intends to secure philanthropic funding for an independent third party evaluation of the Healthy Families program.

By March 31, 2000, the state will submit an evaluation that includes the elements specified in Section 2108(b) of Title XXI.

The evaluation will include an assessment of Healthy Families' effectiveness in increasing the number of children with creditable health coverage. MRMIB will evaluate its effectiveness in meeting this goal by using Current Population Survey data on the proportion of children in families with incomes below 200% FPL who are uninsured. California will also use Current Population Survey data and data collected by the Department of Health Services to assess a change in the percentage of Medi-Cal eligible children who are enrolled in Medi-Cal. In addition, California will use Current Population Survey data to estimate the extent to which Healthy Families has substituted coverage of children under 200% FPL who would have otherwise been covered through an employer.

The March 31, 2000, assessment will also include a description and analysis of the following, as required in Section 2108(b):

- Demographics of children assisted under the state plan.
- Quality of health coverage provided under the plan. As Section 7.1 demonstrates, California will use HEDIS and subscriber disenrollment data to evaluate the effectiveness of care offered through Healthy Families.
- Subsidies and cost-sharing. The state will report the amount of subsidies paid out of state and federal funds and the amount of cost-sharing paid by enrolled families.
- Service area.
- Time limits. Healthy Families offers enrolled children 12 months of continued eligibility. The state will evaluate how many children receive a full year of

coverage, and if not, why coverage was dropped.
- Benefits covered and other methods used to provide health assistance.
- Sources of non-federal funding.

The March 31, 2000, assessment will also evaluate the effectiveness of other public and private programs in increasing the availability of affordable quality individual and family health insurance for children. The state will further review the coordination of its Title XXI plan with other programs providing health care and health care financing, including Medi-Cal and maternal and child health services. The state will report on changes and trends affecting the provision of health insurance and health care to children, with an analysis in health care cost indexes, changes in state demographics and income, changes in the work status of parents and the level of unemployment, and any new state legislation enacted subsequent to the plan that will affect children's health care.

9.6. ☑ The state assures it will provide the Secretary with access to any records or information relating to the plan for purposes of review of audit. **(Section 2107(b)(3)) (42CFR 457.720)**

9.7. ☐ The state assures that, in developing performance measures, it will modify those measures to meet national requirements when such requirements are developed. **(42CFR 457.710(e))**

Federal law does not mandate the establishment of national requirements for performance measures and it is not clear that the development of national standards is advisable or feasible, given the diversity of health care arrangements in their county. However, California intends to remain a leader in the development and use of performance measures.

9.8. The state assures, to the extent they apply, that the following provisions of the Social Security Act will apply under Title XXI, to the same extent they apply to a state under Title XIX: **(Section 2107(e)) (42CFR 457.135)**

9.8.1. ☑ Section 1902(a)(4)(C) (relating to conflict of interest standards)
9.8.2. ☑ Paragraphs (2), (16) and (17) of Section 1903(i) (relating to limitations on payment)
9.8.3. ☑ Section 1903(w) (relating to limitations on provider donations and taxes)
9.8.4. ☑ Section 1132 (relating to periods within which claims must be filed)

9.9. Describe the process used by the state to accomplish involvement of the public in the design and implementation of the plan and the method for insuring ongoing public involvement. **(Section 2107(c)) (42CFR 457.120(a) and (b))**

From the beginning, California has sought to gather public input in the design of the Healthy Families program. In anticipation of developing a Title XXI children's health program, in late July and early August of 1997, the Secretary of the Health and Welfare Agency and the Director of DHS held round table discussions with interested parties and solicited written feedback from constituency groups. Governor Wilson introduced his children's health proposal on August 27, 1997. After introduction of the plan, the Secretary of the Health and Welfare Agency held meetings with numerous stakeholder groups to obtain their feedback on the proposal. Using the Governor's proposal as a framework, the Healthy Families state legislative package (AB 1126, SB 903, AB 217, and AB 1572) was developed through a joint "Health Access" conference committee. The conference committee held several open committee meetings, during which time the public was invited to offer feedback on the Healthy Families proposal.

Since the passage of Healthy Families' enabling legislation, MRMIB and DHS staff has met with numerous interested parties to solicit feedback on the design and implementation of the state plan. Some examples of such interested parties are: the Association of California Life and Health Insurance Companies, the California Association of Public Hospitals, the California Medical Association, the California Primary Care Association, the Local Health Plans of California, the DHS Multicultural Task Force, representatives of the Private Essential Access Community Hospitals, the California HealthCare Foundation, the Los Angeles County Medi-Cal Managed Care Oversight Council, the Children's Hospital Association, the Child Health Policy Advisory Committee, and the Statewide Parent-Teacher Association.

Furthermore, California held two public forums to receive input from the community to implement its children's health program. The forums, held in Oakland on October 21 and Los Angeles on October 24, were hosted by MRMIB's Chairman, DHS' Director, and the Health and Welfare Agency's Secretary. Over 400 people attended and roughly 60 gave public testimony regarding Healthy Families implementation.

DHS has also solicited input specifically relating to the development of the Healthy Families outreach campaign through a series of eight meetings with representatives of counties, program agencies, community based organizations, advocacy groups, health plans and providers.

The public will have the opportunity to offer input as to the implementation of Healthy Families on an ongoing basis, through opportunities to provide input directly to MRMIB or through the Advisory Board established in statute. MRMIB maintains an extensive mailing list for individuals and entities who want to receive information about MRMIB. Mailing list subscribers receive agendas and minutes of Board meetings and draft regulations. MRMIB holds open meetings twice monthly, where it

solicits public input on draft regulations prior to adopting them. In addition to receiving oral feedback from the public during MRMIB meetings, MRMIB staff distributes copies of all correspondence regarding Healthy Families implementation to all MRMIB members.

Healthy Families' enabling legislation also established a 14 member Advisory Panel to advise MRMIB. The chair of the Advisory Panel will be elected by the members and will serve as an ex officio, nonvoting member of MRMIB. The Advisory Panel will include representatives from the subscriber population, primary care clinics, disproportionate share hospitals, mental health providers, substance abuse providers, county public health providers, health plans, the education community, and the business community; physicians who are board certified in pediatrics and family practice medicine; and a representative of a family of children with special needs.

9.9.1 Describe the process used by the state to ensure interaction with Indian Tribes and organizations in the state on the development and implementation of the procedures required in 42 CFR 457.125. **(Section 2107(c)) (42CFR 457.120(c))**

9.9.2 For an amendment relating to eligibility or benefits (including cost sharing and enrollment procedures), please describe how and when prior public notice was provided as required in 457.65(b) through (d).

9.10. Provide a one year projected budget. A suggested financial form for the budget is attached. The budget must describe: (Section 2107(d)) (42CFR 457.140)

- **Planned use of funds, including --**
  - Projected amount to be spent on health services;
  - Projected amount to be spent on administrative costs, such as outreach, child health initiatives, and evaluation; and
  - Assumptions on which the budget is based, including cost per child and expected enrollment.

- **Projected sources of non-Federal plan expenditures, including any requirements for cost-sharing by enrollees.**

The budget for the program for FFY's 1998, 1999 and 2000 is detailed on the chart below. The following pages document the assumptions used in estimating expenditures. These estimates reflect our best assumptions at this point in time, related to projected costs for the Healthy Families program. These estimates should be used for planning purposes and will be updated, if needed, once final decisions have been made for inclusion in the state budget scheduled for release in early January. In addition, the state and local funds reflected as proposed state match are subject to appropriation by the Legislature as well.

Sources of the non-Federal share of plan expenditures will be the state funds for all program elements except for:

- County mental health which will be matched by local funds;
- California Children's Services (CCS) which will be matched by General Fund and local funds;
- Child Health and Disability Prevention program (CHDP) which will be matched by General Fund and local funds.

Start Up Costs. It is not possible for the percentage of administrative costs be as low as ten percent of expenditures until a sizeable number of children have been enrolled. In fact, the estimates below indicate that the percentage of administrative cost will not decline to ten percent until the second FFY of operation. The Federal government must fully participate in the costs to start-up state programs if the children's health insurance program is to succeed nationally.

Healthy Families Program State Plan For Title XXI Assumptions

Payment to Health, Dental and Vision Plans. Current Population Survey data estimates that, for children ages 1 to 18 between 100 percent and 200 percent of the federal poverty level, as many as 580,000 may be uninsured, and thus could potentially be served by the Healthy Families Program. These health services costs are the estimated insurance premium costs as the served population grows over time.

Estimated payment for health, dental, vision per month is $70.25; estimated monthly enrollment by the end of Federal Fiscal Year (FFY) 1, 2, and 3 is 57,000, 261,000, and 501,000 respectively.

Offsetting Premium Payments. The total health services costs will be offset by a monthly premium payment per child paid by the family. These premiums will be collected by the health plan.

Estimated offset of premium payments per child per month is $6.00; estimated monthly enrollment by the end of FFY 1, 2, and 3 is 57,000, 261,000, and 501,000 respectively.

Payments to Enrollment Contractor. The Managed Risk Medical Insurance Board (MRMIB) will contract with a private company to conduct the eligibility and enrollment process. This is the same process that it uses for its three existing programs.

Estimated payment to enrollment contractor per child per month is $3.50; estimated monthly enrollment by end of FFY 1, 2, and 3 is 57,000, 261,000, and 501,000 respectively.

Payments for Application Assistance Fee (One time). The application assistance fee which MRMIB will pay for referrals of eligible subscribers is another feature which will facilitate coordination with public and private entities. MRMIB will specify those agencies and persons in regulation after public hearing, but anticipates authorizing a wide range of entities including insurance agents, county child health and disability prevention program providers, clinics, and hospitals.

Estimated payment for application assistance fee per family is $50.00; estimated monthly enrollment by end of FFY 1, 2, and 3 is 57,000, 261,000, and 501,000 respectively.

Payments to AIM Health Plans. AIM is administered by the MRMIB, which contracts with the private sector to provide subsidized coverage for beneficiaries. To cover the full cost of care, California uses Proposition 99 tobacco tax monies to subsidize subscriber copayments and contributions, while the subscriber pays two percent of

their average annual income.

Estimated payments to AIM health plans average $4,888,190 per year.

California Children's Services (CCS). The CCS Program component of the Healthy Families Program reflects estimated costs of providing services for the eligible children (under 200% of poverty) enrolled in CCS. CCS provides specialty and subspecialty services to children with special health care needs which require case management and authorization of services to ensure that appropriate treatment and services are provided. CCS will be responsible for all medical, dental, and vision services necessary to treat an enrolled child's CCS eligible condition in coordination with the Healthy Families Program plan delivery of providing the primary and preventative health care services.

Average cost per eligible per month is $180.50; estimated monthly enrollment by end of FFY 1, 2, and 3 is 2,048, 9,377, and 18,000 respectively. It is also assumed that the county and state will participate equally in the match requirement.

Child Health Disability Prevention (CHDP) (Without EDS Costs). The CHDP estimate reflects payment to CHDP providers for screening exams and initial follow-up treatment for new Healthy Families Program enrollees during a period up to 30 days during which their application to the Program is pending. It is anticipated the CHDP providers will be a major source of referral for the Program.

Average cost of CHDP screen for age 1-18 is $65.96 and average cost of 30-day follow up treatment is $18.50. It is estimated that 12,500 enrolled first month and 8,000 each additional month through June 1998; thereafter, 10,000 enrolled each month through June 1999.

Mental Health. The mental health component of the Healthy Kids program represents the total estimated costs of providing mental health services to children who are under 200% of poverty with serious emotional disturbance (SED) consistent with the Bronzan/McCorkadale Act. These services are provided through a single, local, public entity because the expertise and resources for serving this special needs population is currently in the county mental health programs.

Average cost per child per month is $220.00; estimated monthly enrollment for FFY 1, 2, and 3 is 1,710, 7,830, and 15,030 respectively.

Accelerate Coverage of Children Under 100% of FPL. The 100% program currently provides coverage to children who have income in excess of the maintenance need but less than 100% of poverty if they were born after September 30, 1983. The program is being expanded to cover children under the age of 19.

Average cost per child is $89 per month; estimated number of children is 15,818 per month.

Asset Waiver for Children. Resources will not be counted in determining the Medi-Cal eligibility of children with income within the various Percentage Program limits.

Average cost per child under 15 years is $48, and 15-18 years is $89; estimated number of 67 children eligible is 33,935 per month.

One Month Extended Eligibility When Income Increases. All Medi-Cal Only children discontinued from Medi-Cal or given a share of cost will be given an additional month of zero share of cost Medi-Cal in order to give them time to apply for the Healthy Families Program.

Average cost per child is $43 per month; estimated number of children eligible is 52,391 per month.

Statewide Outreach Campaign. The Department will implement various activities to provide information to families regarding Medi-Cal and the Healthy Families Program.

Full year outreach activities are estimated at $12 million annually.

DMH County Administration. This is the total estimated administrative cost of providing mental health services to the eligible children.

Medi-Cal Conforming Costs - County Administration. This represents the total estimated share of cost for counties providing a) Accelerate Coverage of Children Under 100% FPL, and b) Asset Waiver for Children services.

EDS Costs - Fiscal Intermediary (FI). Provider reimbursement for all fee for service elements of expanded access would be processed by the Medi-Cal FI through an automated payment system integrated with CA-MMIS. It is assumed that all providers would utilize the HCFA 1500 and UB92 standardized Medi-Cal claim forms as well as the CHDP PM 160. Initial analysis of the CHDP providers system could be used as cost effective model for expanded access for the Healthy Families Program. While this system will require some level of enhancement and will be contingent upon the final parameters identified for implementation, it is anticipated that these modifications can de accommodated on a timely basis.

Ongoing operational costs are estimated to be $1,444,160 annually.

State Administration - MRMIB. MRMIB will administer the Healthy Families Program, and will provide health care for approximately 580,000 children of moderate income working individuals through subsidized private health insurance plans. MRMIB is requesting 18 positions and $1.600 million ($560 thousand General Fund) in the current state fiscal year; and 21 positions and $2.156 million ($755 thousand General Fund) for the state fiscal year 1998- 99.

State Administration - DHS. The Department of Health Services is requesting 19 positions and $2.679 million ($937 thousand General Fund) in the current state fiscal year; and 19 positions and $2.836 million ($993 thousand General Fund for the state fiscal year 1998-99.

This request is necessary to meet the requirement of the Healthy Families legislation, conduct 68 the activities necessary to expand Medi-Cal health coverage for low-income uninsured children, and provide education and outreach activities.

Section 10. Annual Reports and Evaluations (Section 2108)

10.1. Annual Reports. The state assures that it will assess the operation of the state plan under this Title in each fiscal year, including: (Section 2108(a)(1),(2)) (42CFR 457.750)

10.1.1. ☑ The progress made in reducing the number of uncovered low-income children and report to the Secretary by January 1 following the end of the fiscal year on the result of the assessment, and

10.2. ☑ The state assures it will comply with future reporting requirements as they are developed. (42CFR 457.710(e))

10.3. ☑ The state assures that it will comply with all applicable Federal laws and regulations, including but not limited to Federal grant requirements and Federal reporting requirements.

Section 11. Program Integrity (Section 2101(a))

☐ **Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan, and continue to Section 12.**

11.1 ☑ **The state assures that services are provided in an effective and efficient manner through free and open competition or through basing rates on other public and private rates that are actuarially sound.** **(Section 2101(a)) (42CFR 457.940(b))**

11.2. The state assures, to the extent they apply, that the following provisions of the Social Security Act will apply under Title XXI, to the same extent they apply to a state under Title XIX: **(Section 2107(e)) (42CFR 457.935(b))** ***The items below were moved from section 9.8. (Previously items 9.8.6. - 9.8.9)***

- **11.2.1.** ☐ **42 CFR Part 455 Subpart B (relating to disclosure of information by providers and fiscal agents)**
- **11.2.2.** ☐ **Section 1124 (relating to disclosure of ownership and related information)**
- **11.2.3.** ☐ **Section 1126 (relating to disclosure of information about certain convicted individuals)**
- **11.2.4.** ☐ **Section 1128A (relating to civil monetary penalties)**
- **11.2.5.** ☐ **Section 1128B (relating to criminal penalties for certain additional charges)**
- **11.2.6.** ☐ **Section 1128E (relating to the National health care fraud and abuse data collection program)**

Section 12. Applicant and enrollee protections (Sections 2101(a))

☐ **Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan**.

Eligibility and Enrollment Matters

12.1 Please describe the review process for eligibility and enrollment matters that complies with 42 CFR 457.1120.

We are currently reviewing the impact and possible changes that may be necessary to comply with the newly adopted federal regulations regarding eligibility appeals and continuation of coverage when a SCHIP member appeals a decision (section 457.1130(a), 457.1140(d), 457.1150(a), and 457.1170. The changes which may be necessary will be implemented in January, 2003 because contractual changes with the administrative vendor may be necessary to implement them. We will provide more detail on our process for CMS when the contract is finalized.

Definition:
MRMIB defines an 'Appeal' as correspondence received from an applicant expressing his or her disagreement with a decision made by the Healthy Families Program. An appeal must be received by the HFP administrative vendor or MRMIB within 60 days of the initial written decision or action notification. HFP will only consider appeals related to decisions pertaining to:

1) Program Qualifications (e.g., on no cost Medi-Cal, employer sponsored insurance within 90 days, disenrolled for non-payment within 6 months, etc.);
2) Eligibility determinations (e.g., income below guidelines, treatment of step-parent income, income above guidelines, etc.);
3) Effective date of coverage (e.g., enrollment delayed, application processing delay, etc.).

All eligibility determinations result in a written notice to the applicant, as required in 457.1140(c) of the CFR. Decisions with a negative impact to the family include a written determination and description of the appeal process. This includes decisions regarding ineligibility during initial application and the annual review, first level administrative decisions, and second level administrative decisions. This is consistent with the requirements in section 457.1180 CFR. Any appeal that does not meet at least one of the three appeal criteria listed above, or is received beyond the specified timeframe (i.e., 60 days), is defined as a Program Review.

HFP Appeal Process:
The Healthy Families Program has a three step appeals process. These processes are

referred to as:
1) First Level Administrative Review.
2) Second Level Administrative Review.
3) State Administrative Hearing.

First Level Administrative Review:
First level administrative reviews are written appeals received by the HFP administrative vendor or MRMIB for the first time. First level administrative reviews must be received within 60 days of the date on the decision notification. First level administrative reviews will be processed by the HFP within 30 days of receipt.

Exceptions:
The HFP administrative vendor will forward all first level administrative reviews to MRMIB within five (5) calendar days if:

1. The appeal includes outstanding medical bills or expenses.
2. The appeal is of a sensitive nature and the referral has been approved by a HFP administrative vendor supervisor.

These exception criteria comply with provisions outlined in section 457.1160(a) regarding the need for expedited review when there is an immediate need for health services.

If a first level administrative view is denied, the applicant will be notified of his or her right to request a second level administrative review with the Executive Director at MRMIB.

Second Level Administrative Review:
Second level administrative reviews are appeals to first level administrative review decisions made by HFP. Second level administrative reviews must be received within 30 days of the first level administrative review decision notification.

If a second level administrative review is denied, the applicant will be notified by the Executive Director of MRMIB of their right to request a State administrative hearing.

State Administrative Hearing:
An applicant may request a State administrative hearing only if he/she has complied with both the first and second level administrative review processes. An Administrative Law Judge (ALJ) conducts administrative hearings. The ALJ will only address issues or decisions related to eligibility determinations, disenrollments, and/or effective date of coverage.

Program Review:
Program reviews are written appeals received by HFP or MRMIB which do not meet at least one of the three appeal criteria or are not received by HFP or MRMIB within the specified time requirements (i.e., 60 days for first level).

If a program review is denied, the applicant will be notified of the decision, that a Program Review is not an appeal and that there are no appeal rights.

Health Services Matters

12.2 Please describe the review process for health services matters that complies with 42 CFR 457.1120.

MRMIB complies with 42 CFR 457.1120(a)(2)b using the statewide review system which is required of all health care service plans operating in California, including HFP participating plans. This system is enforced by the California Department of Managed Care (DMHC). The statewide review system provides an impartial review of any health care service eligible for coverage and payment under a health plan contract. The issues that are handled through this process include:

- Accessibility
- Coverage/Benefits Disputes
- Appeals of Denials of Care/Payment
- Quality of Care
- Billing and Financial
- Attitude and Service

These issues handled through the statewide review system are consistent with the issues that would otherwise be addressed by 42 CFR 457.1130(b).

Premium Assistance Programs

12.3 If providing coverage through a group health plan that does not meet the requirements of 42 CFR 457.1120, please describe how the state will assure that applicants and enrollees have the option to obtain health benefits coverage other than through the group health plan at initial enrollment and at each redetermination of eligibility.